- *Public Relations and Financial Problems*
- *Operating a Hospital Blood Bank*
- *How to Test Rubber Gloves*

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the

Modern Hospital

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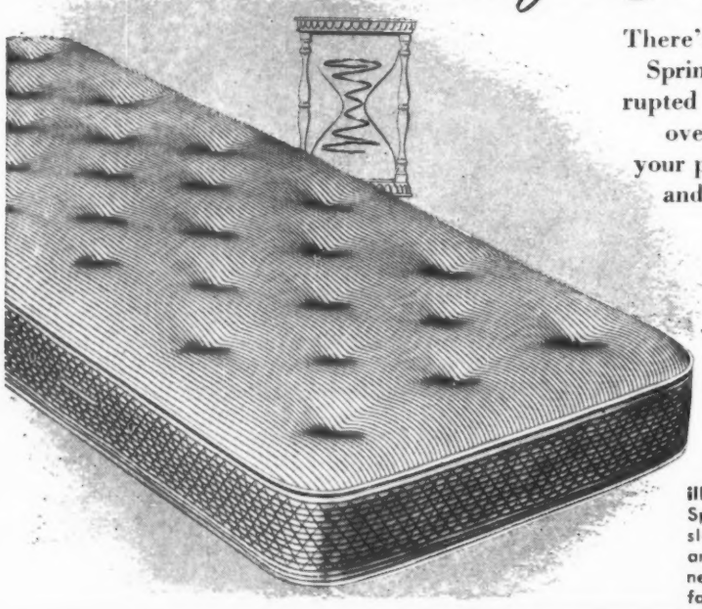

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THE MODERN
HOSPITAL

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In this issue:

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AMONG THE AUTHORS

Lawrence Drake first became interested in hospital problems a little over a year ago, when, as public relations adviser to the American Society of Anesthesiologists, he started visiting hospitals to watch operations. His first hospital article was published in *Nation's Business* last November. "It created a bigger stir than I anticipated; some 30,000 reprints have been distributed by various hospitals and business organizations," he reports. Mr. Drake's articles on economic and sociological subjects have been appearing in *Nation's Business, Collier's* and other magazines for some years. In the early 1930's he was in Europe as a correspondent for the *New York World,* and, later, as editor of an American publishing house. Many of his articles in American magazines have dealt with the economic problems of European countries. Mr. Drake believes that his background enables him to view hospital problems in terms of their broad social and economic implications.

Nena D. Osterud is a graduate of the University of Washington School of Home Economics and spent the first three years of her professional life as a dietitian at Northern State Hospital, Sedro Wooley, Washington; the next three years as field nutritionist for the Washington State Tuberculosis Associaton, and the third three years as assistant to the manager at the University of Washington Commons. Then the three-year pattern changed, so that she has now been for over seventeen years the senior assistant dietitian at King County Hospital, Seattle, in charge of all food production for both patients and personnel and of the cafeteria which serves the whole hospital staff and personnel. **Mary W. Northrop** has been associated with Miss Osterud for seventeen years, and their joint hobby has been drawing plans for hospital dietary departments. Miss Northrop has served on the executive board of the American Dietetic Association.

Dr. August B. Korkosz learned about blood banks the hard way, by managing one before anybody knew very much about how they ought to be managed. "At first we did not know whether or not the blood bank would be a success, and no help was available," he recalls. "For the first few months I personally washed the apparatus, drew the blood, and performed all the chores incidental to the work. The value of the blood bank was established soon after it was initiated, and it has grown steadily since then."

That was at Cook County Hospital, Chicago, not long after Dr. Korkosz was graduated from the Albany Medical College, Albany, N.Y. Since that time, Dr. Korkosz has also supervised the operation of blook banks for the army medical corps in the East Indies and the one at Ellis Hospital in Schenectady, N.Y.

D. H. Radler is wired to the hospital field in several directions. His mother does hospital fund raising in New York City, his father-in-law practices medicine in Indiana, and his wife is research assistant for a hospital planning consultant. Mr. Radler himself, who is studying for his master's degree at the University of Chicago, served for a time as a member of the personnel staff at Michael Reese Hospital and has been a personnel consultant for a number of other hospitals.

Roving Reporter

Idea for Hospital Day

Although National Hospital Day for 1948 is a thing of the past it's never too late, or too early for that matter, to jot down ideas that may be used to attract public attention to that occasion. Which reminds us of the successful party held this year by the Long Island College Hospital in Brooklyn, N.Y.

Getting enough people out to make open house in a big metropolitan hospital worth while presents a problem, as those who have tried it know only too well. Because this year happened to be the ninetieth anniversary of Long Island College Hospital it was decided that its official observance should fall on May 12, thus affording a double cause for celebration. At the same time it was agreed that sponsorship by the school of nursing would assure the presence of families of student nurses and also help the recruitment of students for the incoming classes.

Accordingly, invitations were issued with a large birthday cake sketched on the cover in the center of which, completely surrounded by candles, were the white capped heads of a group of nurses. These were widely distributed to parents of students and friends of the hospital with the result that when the day arrived guides were kept busy taking visitors on tours of inspection and hostesses at the tea table had to keep sending for fresh supplies of beverages and sandwiches.

The moral of this is that ninetieth anniversaries don't come every year and when they do arrive, it's time to do something about them.

Only the Four Walls

"Too often patients get the impression that the hospital is just the four walls of the room they occupy and the services they see.

"They do not comprehend the work necessary to provide medicines, x-rays, solutions, food, clean linen, and all that contributes to their care. They have no understanding of the painstaking labors behind the scenes."

It is Dr. Warren F. Cook speaking or, rather, writing, for the quotations are from the foreword of as striking a mailing piece as has come out of the hospital field in some time.

For Dr. Cook and New England Deaconess Hospital have a new idea in a 28 page booklet called "Serving the Patient." The idea is this:

Mrs. John Pearce was a surgical patient—perforated ulcer. In making administrative rounds, Dr. Cook looked in on her and asked her what she thought of the hospital. Said Mrs. Pearce:

"Oh, dear—just my luck. I have a chance to make a complaint and I can't. Everything's been wonderful." She paused and considered. "There is one thing though: If you ask what I think of the hospital, I shall have to say I don't know enough about it to tell you.

"To me, as to most patients, Deaconess is just a young woman who took some statistics when I entered, and a few pleasant nurses on this floor. The whole hospital is this little room and a few people who come in here—nurses, technicians, the ward woman who cleans, and, of course, the doctors. I had an operation, but didn't even see the operating room."

Mrs. Pearce's husband had commented to her, she related, that it must take good organization to run such a big institution.

Then and there Dr. Cook made a date with Mrs. Pearce—or so the story goes—to bring her husband with her six weeks hence and they would tour the departments from cellar to attic.

Mr. and Mrs. Pearce present themselves, and Dr. Cook takes them on the informal tour described in the booklet. The reader goes along, hearing all the conversation and getting occasional glimpses of what the Pearces are seeing through close-up photographs.

Since the entire booklet is conversation, it reads along so easily and entertainingly that it is almost impossible not to follow the tour through laboratory, radium and x-ray department, outpatient service, laundry, maintenance rooms, nursing department, thrift shop, pharmacy and finally out the door.

The Pearces see how crowded things are—"to shift a desk 6 inches in the Deaconess Building necessitates taking down a partition in Palmer"—and they

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"Superior to any other type we have used . . . Last much longer without repair . . . More comfortable."

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depart, impressed with the complexity of an institution of health and, also, no doubt, with its needs in the near future.

They Deserved the Space

Five columns of space in a Sunday newspaper would run into dough, if a hospital had to buy it, but often local hospitals can get it for nothing—if the administrators will just take the time to give a news writer the real dope.

The Sunday Telegram of Elmira, N.Y., recently gave the two Elmira hospitals the kind of reader interest they could not have achieved through paid advertising in order to tell the public about rising costs.

A posed photograph, four columns wide, showed a nurse with a gauze mask, standing before a food tray, a pile of gauze, a collection of drugs, and a pile of sheets. The caption was: "How Inflation Spiral Sends Hospital Costs Up," and the photograph was lettered to show 100 per cent and more rises in the prices of the items shown.

A series of two column headlines was able to tell the whole story to any reader too hurried to read the full five-column report.

Some of the headlines were: "Quality Cannot Be Reduced — Rising Costs Plague Elmira Hospitals"; "Plenty of Unpaid Bills"; "Seven-Year Rise in Expense"; "Per Diem Up Nearly 100%"; "Endowment Income Shrinks"; "Volunteer Work Fills Gap"; "Selfless Intra-City Service"; "Rochester Regional Council"; "When Collections Fall Off."

William D. Entley, superintendent of Arnot-Ogden Memorial Hospital, Elmira, N.Y., supplied the newspaper with figures on his hospital, and Sr. Mary Adelaide of St. Joseph's filled in with facts on hers.

The chief reason the newspaper gave its two local hospitals the kind of publicity they so badly need at the moment is that the institutions work well together. Two Sisters taught pharmacology to Arnot-Ogden nurses last year, and Dr. Samuel E. Cohen, pathologist at Arnot-Ogden, worked extra hours at St. Joseph's until its newly engaged man could get on the job.

Information is constantly being exchanged between the two hospitals; short cuts on any task and even cost studies are freely exchanged. That sort of cooperation will make almost any newspaper editor interested in presenting a united hospitals' story.

18 Miles Up—and Down

We have a speaking acquaintance with a caged animal who travels as much as 18 miles a day. His name isn't Leo, and he doesn't get free board and room at the zoo. Our animal acquaintance inhabits a hospital and could be called Homo sapiens, or maybe just a Poor Sap. He does not go round and round his cage or to and fro; his progress is up and down.

Sometimes our caged animal is a union man, in which case he is not a Poor Sap but a Plutocrat. But union or nonunion, he is an elevator operator, and Pittsburgh's Presbyterian has clocked an average specimen at 18 miles per eight-hour day.

Presbyterian figures that its three elevator operators carry nearly 40,000 passengers a day, or 14,600,000 persons a year; that is seven times the population of Allegheny County.

No matter how well the animals in the hospital's three cages perform, they cannot guarantee an opening door on any given floor whenever someone pushes the call bell. The statistics are designed to give those who wait for Presbyterian's elevator cars a little more understanding when service is not instantaneous.

READER OPINION

For Biennial Conventions

Sirs:

Perusing the July issue of The MODERN HOSPITAL, I noted the editorial comment on the Middle Atlantic Hospital Conference (*including the proposal that regional and national hospital conventions be held biennially, in alternate years.*—ED.), a suggestion which strikes me very favorably.

I know that the move to have the American Hospital Association meeting every two years, with bang-up hospital conferences in the intervening years, will take a lot of selling to accomplish results. I consider the suggestion a good one, however, and I most certainly will help to plug for such results.

A. G. Engelbach, M.D.
Cambridge, Mass.

Dirty Linen

Sirs:

In these days when nursing service is at a premium, I am at a loss fully to understand why Carl C. Lamley, in his article entitled "Linen Stains Go Down the Drain," in the August issue of The MODERN HOSPITAL, refers to the nursing time saved in the use of automatic washers.

There is no argument about the method used to remove stains, but my objections are these:

1. Why use nurses for this service?
2. It is, or should be, uneconomical to use professional personnel for non-professional service.
3. It deprives patients of much needed nursing service during the time the nurse loads and unloads the automatic washers.

Should the service of these washers not be allotted to the laundry or housekeeping personnel? Unless this is done, it would seem to me that nursing service as well as linen stains go down the drain.

Edna Davidson, R.N.
Pierre, S.D.

Sirs:

The objections listed hold considerable merit. I have found it convenient, when calculating time expended in patient care, to include under nursing service not only registered nurses, but orderlies, aides and auxiliary or practical nurses as well. In a small obstetrical department, it is not always possible to draw rigid lines between duties to be performed by various classifications of personnel. In obstetrics, we must maintain a fixed staff that is adequate to care for the average patient load. When this patient load is below average, auxiliary help on the floor would not be economical. Conversely, when it is high, it is sometimes necessary to transfer personnel from other departments.

You have suggested using either housekeeping or laundry personnel in lieu of personnel assigned to the nursing service. I think this, again, would be a problem for the individual institution, depending upon the activity in the obstetrical service, the location of the utility rooms in relation to the delivery suites, the availability of low-cost personnel, the location of the laundry, nursery routines, and other factors.

The article, as written, was intended to offer some solution to the handling of stained linens within the hospital and was not intended to dictate the type of personnel that should perform the operation. In our instance it is most practical that the procedures outlined be handled by the nursing service. This may not necessarily be true in other institutions of like size.

Carl C. Lamley
Administrator
Highland Park Hospital
Highland Park, Ill.

Locked Up

Sirs:

You have received deserved praise for the editorial "Make Mine Moral." It would add to your luster as moral to say something editorially about the great wrong being done to those wrongfully incarcerated in "mental hospitals" and to those who are kept from getting mental treatment when they need it, by the entirely unnecessary and unpardonable "overcrowding." An immense proportion of those locked up as mentally ill are not in the least proper subjects for being so treated.

EDITH G. G. GRAFF, M.D.
Greenup, Ill.

# of medicine

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Demote or Discharge?

Question: If an employe is transferred to a higher position, which it is found later he is unable to fill satisfactorily, it is advisable to return that employe to his former position, or to discharge him?—A.B.B., Calif.

ANSWER: This question is difficult to answer. The personality and abilities of the individual employe will, to a large extent, determine whether he should be returned to his former position or dropped from the organization.

Of course, there is always the possibility of finding another place in the hospital so that the employe will not have to return to his former department but can be retained on the hospital staff in some other capacity.—E. W. JONES.

A Fair Percentage

Question: When the doctor who conducted all our anesthesia, having his own equipment, died some two years ago our hospital purchased new equipment and one of our young doctors in general practice started giving the anesthetics. We get 20 per cent of his fees. This is growing into quite a business. From Jan. 1, 1948, to July 1, 1948, he has made $4755. The hospital collects the fees. I feel this is more or less a sideline for him because he is at the hospital each morning, having only afternoon office hours, and another doctor relieves him any time he wishes to be away.

At the rate this volume is increasing, and with the hospital furnishing equipment and all supplies, even liability insurance, I feel we should have at least one-third, instead of 20 per cent. The doctor has no contract but simply stepped in when the other doctor died very suddenly.

What do you think would be a fair percentage for the hospital?—G.H., Iowa.

ANSWER: The first question is: Just how competent is this young man to conduct the kind of anesthesia which your patients should have for complete protection? Has this young doctor made any effort to get special training in anesthesia so that he is not just another "ether dripper"? If he really is capable of doing the job right and is also certain that those who relieve him are capable, it would seem to me that some such financial arrangement as follows would be equitable:

1. Guarantee him a minimum salary of around $2400 a year.

2. Count this salary, plus all other direct expense as figured in accordance with the standard American Hospital Association manual on accounting.

3. Then allocate the proper proportion of all overhead expense to the department. Here you should take into consideration depreciation expenses totaling from 10 to 20 per cent of the total area occupied by the operating room suite. These indirect expenses should also include the proper allocation of all administrative expenses as calculated in accordance with the A.H.A. chart of accounts.

4. Put this total expense up against total cash receipts for the department. Then, after the hospital has received a net income of about $150 a month from the returns, split the rest fifty-fifty between the hospital and the anesthetist.

This plan is in operation in many hospitals and has proved to be entirely satifactory.—E.W.J.

Mark-Up on Drugs

Question: Can you provide me with any information as to what is an acceptable mark-up on drugs used in hospitals? I cannot recall seeing any article in hospital magazines, nor have I heard anyone express an opinion on the subject. It seems to me that there should be a differential as to drugs taken orally and those injected. This is based on the fact that a considerable amount of nurse's time is required in administering and injecting the drug.—A.C.O'C., Ohio.

ANSWER: Most of those who have studied the problem carefully feel there should not be separate charges for anything but a few of the particularly expensive drugs, such as penicillin and streptomycin. Many people feel that there should not be a special charge for these drugs, but that the average per patient per day cost for all drugs used in the hospital, plus a 20 or 25 per cent mark-up, should be included in the regular day rate charge. We know from experience that one of the things that irritates patients most is the multitude of special charges for extras. Patients will accept an increase in the per day charge of 50 cents with much better grace than they will accept so many extra charges on their bills. I don't think that whether a drug is taken orally or injected should have the slightest bearing on the charge for the drug. After all, the injection of drugs is part of the normal nursing or house staff procedure and should be a regular part of the regular daily rate charge.—E.W.J.

Public Relations

Question: Our hospital has great need for a good public relations person and I have been trying to sell the trustees the idea of employing one. At last the trustees have agreed and I am turning to you for help or suggestions as to how a well trained public relations person might be obtained. Could you tell me through what channels I might go to find such a person?—M.C., Mass.

ANSWER: There is question in our minds as to whether a small hospital should spend the money for a full-time director of public relations. Many hospitals of 300 beds and under develop splendid public relations programs through the employment of a local newspaper man or woman on a part-time basis. Then, too, in some of the larger cities of your area there must be some good public relations firms or public relations departments of ethical advertising agencies. It is often real economy to employ these people to give part-time services.—E.W.J.

Personnel Work Full Time

Question: What size hospital requires a full-time personnel director?—V.K., Nev.

ANSWER: So few hospitals have a personnel director and hospital experience in this work is relatively so limited that criteria of this nature, quickly available to industry, are a matter of conjecture in hospital circles. We believe that industry in general is of the opinion that a full-time personnel director is indicated in any unit employing 300 or more persons. Personnel relations are so complex in this area that it might be well for a hospital to employ a person trained in personnel management who could combine this function with some other duty.—WILLIAM J. DONNELLY.

Looking Forward

One Sided?

EVERYBODY liked the new program at the Atlantic City convention—especially the morning discussions, where scheduled speakers stuck to their seven-minute assignments and the greater part of the time was left for free-style arm-waving. The program planners are to be congratulated for this break with tradition and boredom.

Another time, two improvements might be made in this type of program. As it turned out, more time might profitably have been scheduled for each subject; in several cases the discussion was just hitting its stride when the time was up. However, this is a tricky business. There's no way of knowing in advance just how one of these sessions will develop, and there's nothing worse than a discussion that falls on its face before the bell rings. In this case, it was better to be short than long.

The other need seems more important: The programs suffered from a unilateral approach to controversial subjects. Imagine a discussion of specialists' contracts—and not a radiologist in the room!

Could Be

LIKE the international situation, the nursing problem has no one right answer, and any plan that is advanced has more critics than supporters. In the Atlantic City discussion of auxiliary nursing personnel, however, it became clear that not many hospitals are going to take the high road. The all-graduate staff is a rarity today, it would seem, and may soon become extinct. Practical nurses and nurses's aides are here to stay, it was generally agreed. Beyond that point, there are almost as many opinions as there are interested people—a circumstance that makes uniform, decisive action unlikely if not impossible.

As the arguments about what ought to be done go on and on, hospitals everywhere are doing what has to be done—filling the gaps on their floors with practical nurses, if they can be had, or nurse's aides, if *they* can be had, or hiring whoever can be hired and training them on the job to do the simpler nursing chores. In a few cities, hospitals have joined together, through their hospital councils, independently or in cooperation with public school systems, in recruitment and training programs.

As these involuntary experiments are carried along from month to month, it is important to keep the score of their successes and failures. The sensible suggestion has been made that each hospital should have a nursing study committee continually observing the nursing service and evaluating results. Such a committee, it was pointed out, should include representatives of the nursing, medical and administrative staffs, as well as someone who represents the patient's point of view.

The patient, as a matter of fact, could turn out to be an important source of enlightenment, if his opinions are considered seriously and are not shrugged off, as so often happens, as the irresponsible babbling of a demented child. It could be, for example, that the attitude of the bedside nurse is just as important to the patient as her education. This finding might shed some light on who should be teaching what to whom in nursing, and that seems to be what all the talking is about. That and the nursing bill—another subject on which the patient might have something to say.

Flaw

TWO instances have come to light recently of an approach to the responsibilities of trusteeship that could easily nullify the good work now being done to interest qualified men and women in hospital careers. In the first instance, the board of trustees suddenly dismissed an administrator who had given satisfactory service for a number of years, for no other reason, apparently, than that another man, mildly qualified and socially acceptable to the board, indicated an interest in having the job. No member of the board has come forward with any criticism of the former administrator's performance,

nor has any such criticism been expressed to him.

The second case also concerns an administrator whose performance, so far as he knew, had been entirely satisfactory. In this case, the board employed a public relations executive, ostensibly to direct a fund-raising and expansion program the hospital was about to launch. Immediately on taking office, the public relations man started releasing turgid statements about the hospital, quoting himself, to the press. Many of his public relations activities infringe on administrative territory and involve administrative decisions.

Under these circumstances, the administrator can go along as diplomatically as possible on the theory that Mr. Public Relations will eventually pop like a gas balloon, or he can make a fight out of it and demand a showdown, now or later, or he can put on his hat and walk out. There are good arguments for and against each of these courses of action. Whichever course he follows, however, the administrator is going to suffer, and so is the hospital.

Probably there isn't anything anybody can do about these and similar cases except regret them. The answer doesn't lie entirely in the realm of "trustee education," either, necessary and valuable as educational efforts are. Until hospital trustees are selected on the basis of their moral and intellectual rather than their social and fiscal qualifications, incidents like the ones reported here are going to keep on happening. It's a major flaw in the hospital system.

O. Leap Year!

MR. O. EWING, the Federal Security Administrator who smiles in May and scowls in September, got himself on the hook in his report to the President called "The Nation's Health." On page 36, Mr. O. Ewing is pretty worried because there aren't enough doctors to go around. "We need more doctors," Mr. O. Ewing says here in 24 point type. "The nation has only about 80 per cent as many physicians as it needs. The most obvious reason for the present shortage of medical manpower is that today more people are making more demands upon existing manpower."

Over here on page 77, however, it isn't the doctor shortage that has Mr. O. Ewing so worried, it's the patient shortage, or rather the money shortage that keeps people from becoming patients: "Perhaps the basic lack of our entire health effort is the absence of any method that would permit every individual to obtain all the services he needs to promote better health. A satisfactory system of health insurance should provide that everyone should have ready access to adequate health and medical services." One of the chief barriers to better care for everybody, Mr. O. Ewing says, is the high cost of modern scientific medical care.

Now Mr. O. Ewing is as slick a hand at easing himself off a hook as the next man, in the Fall of 1948. The answer to this you-find-the-doctor-and-I'll-find-the-patient puzzle, he says on page 95, is a "tooling-up phase" in the program—a three-year wait between the enactment of insurance legislation and the effective date of insurance benefits. "The tooling-up period would be employed to increase medical resources—doctors and hospitals, for example," Mr. O. Ewing explains.

Among many others, students in their fourth year of medical school will be interested to learn how Mr. O. Ewing is going to produce more doctors in a three-year period. As Antonio's friend declares in the opening scene of "The Merchant of Venice": "Now, by two-headed Janus, Nature hath framed strange fellows in her time."

Watch Out for Dips!

AS A prudent man in a tough neighborhood sticks to well lighted streets for fear of being waylaid, the hospital buyer who is concerned for the safety of his patients is likely to make his purchases among known brands of merchandise. By choosing a name that stands for quality and integrity, the buyer protects himself with an implicit guarantee of satisfactory performance and service.

Even on a lighted thoroughfare, however, the traveler may be victimized by pickpockets. Inside the protection afforded by reliable brand names, the hospital may be victimized by pickpocket dealers who advertise branded instruments and supplies for sale as government surplus at cut prices.

Some of this merchandise may prove to be as advertised, but the careful buyer will make absolutely certain that this is the case before placing an order. Many times, hospitals have ordered known brands in cut-rate surplus deals and have found that the merchandise actually delivered was of unknown, inferior quality. Other cut-rate dealers have delivered rejects and grades below those specified.

Surplus property offered for sale through regular government and trade channels has enabled many hospitals to pass legitimate savings along to their patients and their communities without sacrificing safety, and alert buyers will continue to seek and take advantage of these opportunities. In other cases, however, the offering of a reliable brand name by an unknown party in a cut-rate deal should warn the hospital buyer to get his guard up. There may be pickpockets in the neighborhood.

At the Heart of the Hospital Problem:

THE ADMINISTRATOR

LAWRENCE DRAKE
Washington, D.C.

I HAVE been asked quite a few times during the past several years to outline the public relations job which I thought would help put the voluntary hospital on its feet. Time after time I sat down to fill the order, only to find myself stymied by the same dilemma. It was either I blithely sold my friends in the hospital a bill of goods, which I had no interest in doing, or I told them bluntly what it was in the hospital picture that stopped me cold, which I was afraid they would resent. I have finally decided that it is time for those of us interested in the voluntary hospital to stop running around in circles and to become a little blunt.

From a public relations point of view, the job of putting the voluntary hospital on its feet poses a familiar if quite complex problem. What it involves is the adaptation of a corporate enterprise to a new set of deterministic social and economic conditions. By deterministic I mean that these new conditions more or less set the terms for survival.

TWO TARGETS

The voluntary hospital is a corporate enterprise facing such a problem. Conditions favor it. A phenomenal increase in the demand for hospital services, not a drop in demand, is one of the major and paradoxical causes of the hospital crisis. Moreover, there is ample evidence that we have the potential social base to support a voluntary community hospital serving the millions.

For the sake of clarity we can divide the job we face into two parts. Part one concerns the public. Public relations can be defined as the art of creating and maintaining intelligently desirable human relations and intelligently desirable attitudes toward one at all those vital points where such relations and such attitudes affect one's interests and purposes. As far as the hospital is concerned, the public relations problem it faces makes each citizen an "attitude" target and each patient a "relations" target. These two targets give us the hospital problem as both idea and reality.

Facing the public, we need, to start with, a public relations survey to determine what sort of idea of the voluntary hospital we must project. We must find out what the public expects of the hospital; what it expects but is not quite able to express; what it thinks is wrong with the hospital. An honest and intelligent analysis of the results of this survey will give us the outline of the idea of the hospital we must project to win the public. This same outline will give us the shape of the reality we must fashion. For the voluntary hospital is both an idea and a reality and must be handled as such if we are to win for it the broad public support its survival clearly demands.

That would give us the pattern for the adaptation. We all know that successful adaptation is the primary condition for survival. To negotiate the act of adaptation, however, the hospital needs another public relations job. The objective of the second job is to draw the different self-centered economic interests the hospital supports into a working equilibrium. Physicians, surgeons, technicians, nurses, governing board—all must be won intelligently and actively to support the hospital's effort. The hospital must achieve this internal equilibrium of all interests if it is to win the freedom of action it needs successfully to negotiate the job of adaptation.

That is a rough thumb-nail outline of the public relations job the hospital needs. And with that we are smack before the dilemma that has stymied me. Suppose we complete the job, the whole analysis, not only in detail but in brilliant and convincing detail. It will not, under present circumstances, do the hospital any good. It will not, and it cannot, because the voluntary hospital lacks the managerial apparatus with which to do the job. The hospital has not as yet developed the corporate brain center any enterprise of its size and complexity must have if it is to exist on terms other than as a mere uncertain pawn of circumstances. And that is the heart of the hospital problem.

NEEDED: CORPORATE BRAIN CENTER

Let us have a close look at the meaning of this shortcoming. A glance at a manufacturing company, facing a similar problem, will cast some light on the problem we face. The manufacturing company, let us say, has a good product. There should be a healthy market for it. Sales, however, have been dropping. The company's operations have dipped into the red.

To get an objective analysis of what is wrong, the president procured the services of a public relations firm that specializes in marketing problems. After a thorough survey the firm submits its report. The company had gone along too long on the naïve assumption that if it delivers what it thinks is a good product, why everything else must take care of itself. Consumer demand has changed. The report recommends some alterations in the product. A new package must be designed. Some antiquated practices of the sales and promotion forces must be corrected. Human relations with the customers must be improved in a variety of ways. Hand in hand

Presented to the Inter-Professional Council of the District of Columbia.

with these changes, the company must undertake a publicity campaign carefully calculated to overcome some prejudices the public has developed against the product.

In the main, we have here a pattern for adaptation that corresponds to the problem the hospital faces. In the manufacturing company the president has the responsibility for the job. He has the responsibility and the authority to procure the services of experts to deal with these problems. Who is there in the hospital who has the same responsibility and the same authority?

The president of the manufacturing company accepts the proposals. The changes to be made will involve some drastic action. He must deal with the stockholders, the bank, the trade unions, the board of directors, to overcome friction and win the elbow room for action.

With that in mind, he has contracted with the public relations firm to prepare the public relations campaign for the internal job. This job will have to sell the case for the changes to all concerned within the company.

We can assume that the president will do that because we know that it is his business to maintain the different self-centered economic interests the enterprise supports in a working equilibrium that permits him the full latitude for the whole job he must do.

PRESSURES ON ALL SIDES

Who is there in the hospital to do this job? That the hospital does not try to make a profit does not alter the fact that it supports an increasing number of self-centered economic interests, and that each interest seeks naturally to entrench itself and to perpetuate itself. The pressures of these interests in the hospital, as in any business or industry, become a blind force. These pressures will make the enterprise their pawn unless it has a mechanism to cope with them.

The hospital has no such mechanism. Let us go into any department store. We can go to the superintendent's office. What is his job? He is responsible for the management of the physical establishment. Between him and the board of directors is the president. He, not the superintendent, is the key figure in the managerial apparatus. The president has the responsibility for maintaining proper relationships with the employes, the customers, the public at large, the board of directors, the press, the stockholders. He may delegate his powers, but the ultimate responsibility is his. It is his job to keep an eye on trends, and to make all adjustments necessary to maintain the store's competitive position, as regards prices and profits, as well as public relations.

Let us go into any hospital. There is the superintendent. He, too, is responsible, more or less, for the management of the physical establishment. Who is there between him and the governing board? In name, a figurehead; in reality, nobody.

It is not my intention to be critical of our hospital superintendents, or to accuse them of having failed the hospitals as executives. Few if any executive powers are delegated hospital administrators. I do not know a single hospital superintendent who has the authority to act in matters involving the medical profession "according to his best lights and judgment"—though there may be a few such executives in the country. In too many cases even the administrative responsibilities of hospital superintendents are limited by many checks, reservations and frustrating impediments.

Many hospital administrators might well prove astute and competent executives—if given the chance, that is. The shortcoming we are concerned with is not in the administrator. It is in the concept of the hospital, and of hospital administration, on the basis of which the governing boards are trying to run our voluntary hospitals.

Of course, this shortcoming has no importance and may even lack meaning, if we are interested only in the hospital as such. We are interested, however, in a specific type of hospital, not just any kind of hospital. The hospital as a mechanistic and inevitable product of medical progress has an assured future. A glance at the hospital's inevitable future may cast some light on the odds, for and against, that the type of hospital we want—the voluntary hospital—can survive.

The hospital is already the major workshop, as well as the show window, of the medical profession and all of the allied professions, trades and industries. Within the next ten to twenty years we will see the hospital's importance become overwhelming.

Medical science is beginning to make really serious advances beyond the concepts and instrumentation of chemotherapy. Physics and biophysics have already opened to us astonishing vistas of new diagnostic equipment, of new research technics and equipment, as well as of new therapeutic procedures and equipment. From what we have already seen there can be no question but that medical practice in the coming years will become almost totally dependent on costly and complex facilities that only the hospital, as a medical center, will be able to provide.

We are really at the dawn of a new era in hospital expansion. All that makes the fate of the voluntary hospital the more significant, for the fate of the voluntary hospital involves the fate of the medical profession. The individual practitioner will become more and more helpless as the social investment in the tools he needs increases. We can be sure that this investment will increase fantastically. Whoever controls the tools of medical practice must control medicine.

That's the perspective in which the survival of the voluntary hospital must be considered. The hospital as government function involves merely an administrative problem. The voluntary hospital, dependent for its support upon a community effort, involves a gigantic managerial problem. A public dissatisfied with the way the government is running the hospitals cannot refuse to pay taxes. A public dissatisfied with the voluntary hospital means the end.

WE HAVE SOME CHOICE

We are before a dynamic situation. A combination of forces—scientific, medical, social and economic—is shaping the new hospital at an accelerated pace. These forces are deterministic. We cannot go against them. Nuclear physics and electronics, like the public interest in health and the desire of all mothers to have their babies in hospitals, are some of the deterministic forces that make up the matrix of the new hospital.

However, within this deterministic scheme we have a choice. We can let the dynamics of the situation shape their own economic base. That would be the individual solution. Each of us will seek only to get the most possible out of each turn in the situation. Or we can choose through a united effort to influence the situation, with the end in view that the hospital, however it is shaped as a public medical instrumentality, will have the social and economic base we prefer.

But we cannot assume a purely individualistic and exploitative attitude

toward the situation and expect a preferred result that can be achieved only by means of a conscious and united effort. For this much is already clear. We have a hospital crisis because the situation, as it is developing, is clearly unfavorable to the voluntary hospital. If we are to save the voluntary hospital, we must face the conditions working against it and find the ways and means to overcome them.

Let us glance at some of the conditions working against the voluntary hospital. The physician and surgeon make up the dominant self-interested economic group in the hospital. It is of the greatest concern to them that the private practice of medicine be perpetuated. That involves the voluntary hospital. There should be the closest working harmony between this group and the hospital.

However, as we all know, no such working harmony exists. We have no such harmony because we have no common idea of the hospital sufficiently compelling to provide the base for the discipline both need to work in harmony. Impulses that spring largely from unclarified self-interest cannot serve as the source of the vision of the hospital we need here. The hospital has no really clear notion of its rôle. It has been unable to project the idea of the key rôle it is playing in terms that the physician and surgeon could find significant for their discipline. It has been unable to do that because nobody in the hospital has tried to give it an integrated meaning to all who work in it.

PARTISAN AND SELFISH CLASHES

Unfortunately, the position of the physician and surgeon is not even neutral. The individualistic practices and attitudes of both, as well as the attitudes of members of the medical profession outside the hospital, are seriously hindering the hospital from making those adjustments its survival demands. We have a beautiful example of an economic interest, for lack of a clarified attitude, destroying the conditions necessary for its own survival.

The dynamics of the situation are also confusing and dividing the medical profession. For lack of leadership the hospital is made the tool, in too many cases, in the partisan and purely selfish clashes between the different medical groups and personalities. In other words, not only has the hospital failed to impress upon the medical profession the clear mutuality of interests that should unite them in a common effort, but it has failed as well to save itself from the confusion and the cut-throat attitudes prevailing within the medical profession.

Worse, whenever they can, and in every way possible, the hospitals pit their own unclarified economic impulses against the unclarified economic practices of the medical profession. Constantly under pressure, they seek solutions through corporate practices which antagonize and alarm the medical profession. Hospital spokesmen, some of them doctors, will use the public press to blast at some of the medical specialties. The specialties will blast right back.

The serious personnel problem the hospital faces has not been solved. Nor is it in process of being really solved. If the hospital shows itself helpless where positive action is called for, the hospital bureaucracy has become visibly enchanted with the green pastures it sees beyond the open doors of the federal treasury. Getting on the federal gravy train is easier than winning the public support the hospital needs. It is true that a great many of the doctors are pushing the hospitals in that direction. But it cannot be denied that some of our friends in the hospital are not waiting to be pushed.

There is the public. Nearly fifty million Americans are covered by hospitalization insurance. Here is the broad base and the readily available base for the support the voluntary hospital needs. But the public is being systematically confused and puzzled, when not disgusted, by the introversions and curious practices of the voluntary hospital. The result is that this unprecedented interest in hospitalization is being turned, little by little, into another deterministic force that is pushing us slowly in the direction of large-scale government intervention in the hospital.

It is obvious that all in the hospital picture, as far as saving the voluntary hospital is concerned, are working at cross purposes. At the same time the situation is developing in a manner increasingly unfavorable to the voluntary hospital. There is very little we can do about it because there is no instrumentality within the hospital that we can work with. No matter where we begin, no matter how we approach the problem, no matter what remedy we might have in mind, we shortly run up against this frustrating fact.

What is involved is much more than the vulgar question of whether medicine should be practiced on one economic principle or another. What is really involved is the most important issue of our times. It is this. Facing the problems of our times, what can we devise to permit the inescapable increases in the functions of government without increasing the powers of government? To let the government take over the hospital, and thus establish economic control of medicine, would not mean a simple increase in the functions of government. It would amount to a fateful increase in the powers of government, an increase that should make us shudder.

HEART OF THE PROBLEM

We have a cause. If stated properly, it can be made significant to the majority of Americans. We have potentially favorable conditions. The majority of Americans still prefer the voluntary hospital. We have the advantage of a phenomenal interest in hospitalization. Moreover, pride in the voluntary support of community institutions is a deeply ingrained native quality.

We have all that. A sound approach to public relations offers us tested methods for the job to be done.

But the hospital lacks the managerial or executive apparatus for the job. Under these circumstances the voluntary hospital can only continue the ineffectual publicity practices it naïvely perpetrates in the name of public relations. These practices will suffice, for a few more years at least, to give voice to, if not relief from, the perennial agony of the deficit.

Can we bridge the gap between the governing board and the superintendent with the necessary executive apparatus? Can we arouse sufficient interest among all concerned to give the hospital the executive leadership its survival clearly demands?

These questions, as I see the situation, go to the heart of the current hospital problem.

OPERATION TELEVISION:

The Next Step for Teaching Hospitals

RICHARD D. VANDERWARKER
Director, Passavant Memorial Hospital, Chicago

THE doctor smiled from the television screen, jerked his thumb over his shoulder and said, "Ever have a patient like this one?"

The camera swung over in the direction indicated by the doctor and focused on a gross gentleman, obviously well over 300 pounds, who was devouring a 3 inch steak. On the table before him were enough vegetables and other trimmings to provide three meals for an average eater.

Over the speaker came the voice of the doctor. "What is the reason you are so much overweight?"

The fat man chewed a mouthful of steak, washed it down with half a glass of beer, and barked shortly, "Glands!" A burst of laughter rose from hundreds of doctors who were watching the television screens.

Once more the face of the doctor appeared on the screen as he explained that the fat man was a typical case. A complete physical examination had proved that there was nothing whatever wrong with his glands—he just ate too much and had found in self-diagnosis a convenient excuse for his grossness.

FOR LARGE-SCALE TEACHING

Thus began one of the many clinical demonstrations that were part of the week-long series of medical programs televised from Passavant Memorial Hospital as part of the American Medical Association convention in Chicago in June.

The methods of presenting this subject—a discussion of endocrine glands—and other subjects usually confined to the classroom were a triumphant solution to the problem posed for the committee in charge of the show, Drs. Walter Carroll, Stuart Abel and Henry Wilson Jr. They were faced with the task of presenting a variety of subjects in an interesting manner to a potential audience of 1500 doctors and medical students. The subjects had to be dramatized in order to appeal to the eye as well as to the ear and thus forestall a mass walkout by their huge audience.

Twice before, on a more limited scale, television had been used as a teaching medium, once at Johns Hopkins Hospital in Baltimore, and once at New York Hospital. It was known that interest in the surgery was guaranteed. The programs from Passavant, however, represented the first time that clinical procedures were ever televised.

Scripts, not unlike one-act plays, were worked up for each of the demonstrations. Several different scenes were used in each demonstration so that the complete story was told without waste of time. The effect achieved by the multiple camera set-up, with a monitor taking the audience instantaneously from scene to scene, was similar to that achieved with a revolving stage in a modern theater. No time was lost in setting the scene and placing characters for various parts of the "act."

Dozens of patients were used and their presence commanded attention. This was particularly true in demonstrations of various types of prostheses and in heart cases where a newly developed instrument was used to amplify heart and chest sounds so that the audience not only saw the patient but heard the erratic sounds of his heart.

Many hours of rehearsal went into the preparation of each of these programs as the doctors worked out each detail of their presentation with the RCA-Victor engineers and Program Director Tom Grady.

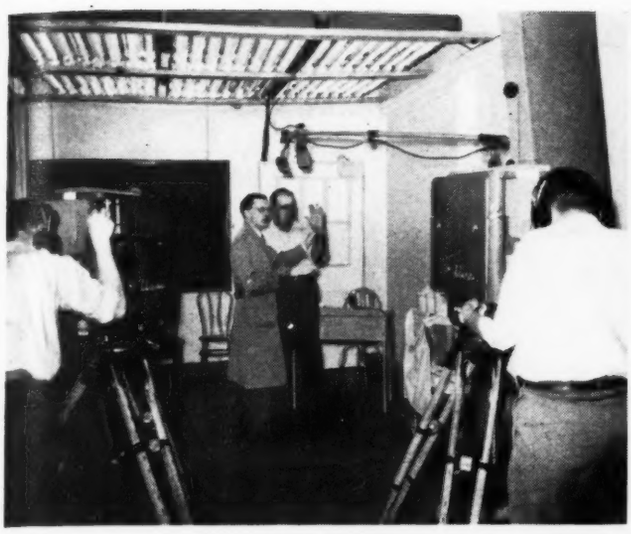
AWAYS A FULL HOUSE

So well did the committee solve its difficulties that seats in front of the sixty-three receivers at convention headquarters at Navy Pier and the Sheraton Hotel were filled at all times. Receivers in Passavant Hospital and across the street at Northwestern University Medical School were also intently watched by capacity crowds.

Various portions of the programs were given over completely to clinical procedures in the fields of internal medicine, orthopedics, cancer, endocrinology, neurology and gynecology.

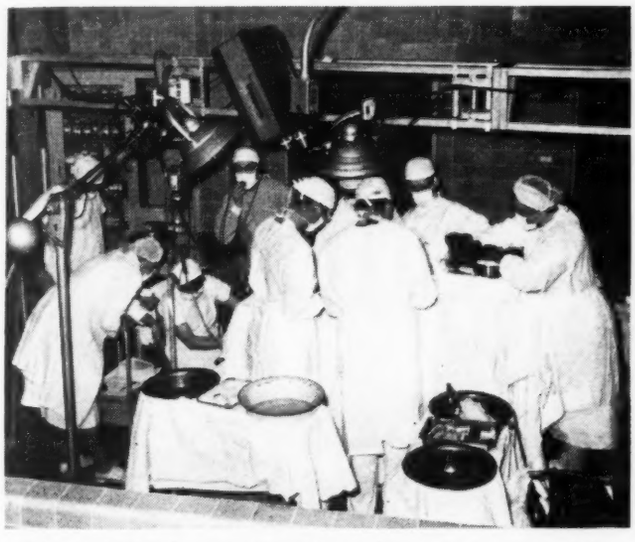
"The programs were planned not only to bring to the visiting physicians and surgeons the latest advances in clinical and surgical methods but also to present a consideration of some everyday medical problems," said Dr. Carroll, committee chairman.

Programs worked out by the doctors also included clinical discussion of the surgery shown. While preliminary work was going on in the operating room, an associate of the surgeon was seen on the video screen, discussing, with the assistance of charts and other visual aids, the operation about to be seen. When the television camera in the operating room was switched into



A doctor is conducting a clinical demonstration before television cameras. One of the long-armed spotlights may be seen in front of left camera.

Dr. J. Roscoe Miller, Dr. Walter Carroll and Mr. Vanderwarker, director of the hospital, ironed out various wrinkles with the video engineers.



The televised operation is under way. A special dress rehearsal was held a few days in advance of the show for the benefit of press photographers.

Overhead lights were attached to the camera rack. Nurses reported that these much brighter lights were cooler than the conventional surgical lights.

A section of the crowd of 600 doctors watching the televised medical programs at the Navy Pier.

R.C.A. contributed the services of trained engineers and installed more than $150,000 worth of equipment.

the circuit, the audience got a close-up view of the site of the operation. The image was so clear at all times as to be as good as the view the surgeon himself had. A running commentary on the operation was given by the surgeon through a tiny lip-microphone which he wore behind his mask.

The technic evolved for the presentation of the surgical operations called for occasional flash-backs to the classroom where further patient demonstrations were given during the more routine parts of the operation.

On the receiving end of the programs broadcast on a direct beam, special frequency, both direct view and big screen projection types of sets were used. The smallest screen measured 15 by 20 inches; the largest was a 6 by 8 foot receiver installed at Navy Pier. A "Television Theater" was set up at Navy Pier to accommodate more than 600 people. Twenty small receivers were set up along the sides of a large hall with the 8 foot screen in the front.

NO LIGHTING DIFFICULTIES

A feature of the show was the complete solution of the lighting problem. Lighting was the principal engineering difficulty in the previous television demonstrations, according to James E. Hague and Edwin L. Crosby, M.D., of Johns Hopkins Hospital, in an article in the April 1948 issue of The MODERN HOSPITAL.

Overhead lights which were shadowproof and explosionproof were installed on the rack that held the television camera. Two lights were placed in each frame and two spots with long arms were used in each of the operating rooms. The long arms made it possible to keep the supporting base back out of the way of doctors and nurses.

The lights, including the spots, were of a new type lent to the hospital for this occasion. The shadowproof feature made it unnecessary to move the lights around during the course of the operations. According to the nurses in the operating room, the lights used not only were much brighter than the conventional surgical lights but also were much cooler.

Each of the patients involved in the demonstrations and those operated on during the surgical portions of the program were asked to sign releases in advance permitting the hospital and the doctors to present them on television. The committee was agreeably surprised to find that none of the patients had the slightest objection.

The measure of success of the week-long program was the comment received both during and after the convention. Many doctors took the trouble to call personally at the hospital or to write or telephone their enthusiastic approval.

Newspaper, magazine and press interest in the programs was at a high peak. Press wire services sent the story across the country and national magazines also carried pictures and articles about the video programs. Publicity was centralized through the public relations department of Northwestern University Medical School. Public relations departments of the other three sponsors of the show, RCA-Victor, E. R. Squibb & Sons, and Passavant Memorial Hospital, cooperated.

A special dress rehearsal was held for the benefit of press photographers a few days in advance of the opening date of the show. This was done to cut down as much as possible the congestion which would have resulted had they been allowed into the surgical amphitheater in large numbers during the programs. Press photographers who requested permission to make shots during the week of the convention were allowed to go in one at a time and were provided with an escort. Uniformed ushers were stationed at all receivers to prevent the taking of pictures from the television screen. A special screen was set up for this purpose in the hospital where a doctor decided which scenes would be photographed.

While this article is principally a report on the television show at Passavant, it is noteworthy that the tremendous success of the programs seems to indicate beyond any doubt that television will be an important part of hospitals and medical schools in the future.

The success with which the doctors and engineers at this show ironed out various wrinkles as they came up has proved that there is no problem which cannot be solved in the use of video as a teaching medium. Its advantages over the old method of demonstrating to surgical students in an amphitheater are obvious. The audience can be multiplied many times, and the view is infinitely better. An indication of the clarity of the operational site is the remark by an Iowa doctor who attended the convention that one of the famous surgeons in the video show, a former teacher of his, now used fewer sutures than formerly in a certain type of operation.

The element of immediacy in television is one of its chief advantages over movies as a method of teaching. Dr. Malcolm T. MacEachern, director of the American College of Surgeons, stated that television far surpasses movies for instructional purposes because movies portray ideal technic after extensive rehearsal while television adds the "living element" of the surgeon encountering the unexpected with the outcome hanging in the balance, while doctors and students tensely follow each move on the video screen.

Another important element to be considered is the space-saving feature. It seems likely that in future hospital construction the conventional surgical amphitheater will be eliminated and the space will be utilized to better advantage.

The television experience at Passavant proved that professionals are not needed to operate the television camera. Much of the time during the show the cameras were operated by medical students who were easily and quickly trained by the engineers.

ALL PATIENTS RECOVERED

All of the patients who underwent surgery during the week of the show enjoyed normal recovery, including the baby delivered by cesarean section, who contributed a little drama at the show on her own by waiting a few tense minutes before emitting her first cries which were heard with relief from receivers blocks away from the hospital. An unusually rapid recovery was made by the "blue baby," a six year old boy, who was sitting up in bed playing with a huge rubber ball two days after the operation, his skin healthy looking and relieved of its cyanosed coloring for the first time in his life.

The success of the show was brought about by the close cooperation of representatives of the four sponsors, Passavant Memorial Hospital; Northwestern University Medical School whose dean, Dr. J. Roscoe Miller, conceived the idea for the television programs; E. R. Squibb & Sons, which donated a large sum of money to defray some of the cost, and the RCA-Victor division of the Radio Corporation of America, which contributed the services of a crew of trained engineers and lent and installed more than $150,000 worth of equipment.

We attempt to apply current hospital literature to our own situation.

OUR JOURNAL CLUB

Keeps us up with the news

SISTER MARIE

Administrator, Providence Hospital, Washington, D.C.

AFTER experimenting successfully for several months, the members of the Administrator's Journal Club of Providence Hospital, Washington, D.C., are convinced they have found the way to keep abreast of the tide of hospital literature. Like all good things, the club grew out of a recognized need, and it serves to keep each of its twenty-two members in touch with important developments in the hospital field.

The flow of hospital periodicals across the administrator's desk had grown to phenomenal proportions, but for the most part this mine of rich, interesting material could only be touched on the surface. The overbusy administrator felt that not only she but also many of her department heads were missing valuable information and ideas for improvement, but how, with the press of daily activity, could any of them hope to cover even a substantial portion of it?

As an experiment, department heads, floor supervisors, and nursing faculty members were invited to participate in a journal club. The objectives were to be: (1) to review such current periodicals as The MODERN HOSPITAL, *Hospital Progress, Hospitals, Hospital Management, American Journal of Public Health, American Journal of Nursing, Trained Nurse and Hospital Review, Journal of the American Dietetic Association, Hospital Pharmacist, Trustee* and a score of others; (2) to compare situations and conditions reported on with those existing in the hospital; (3) to apply suggested improvements and comment on their practicability in this hospital.

The club meets twice monthly on Wednesday morning at 8:30 for one hour. A week before the meeting, three or four members are notified by letter from the chairman that a particular periodical has been assigned to each of them and a report on the most interesting articles will be expected.

After the report has been given, an informal discussion takes place with questions frequently directed to the person reporting. A healthy airing of views and opinions and the sharing of personal experience are often prompted, to the benefit of all present. One person reporting might feel that a certain suggestion or new procedure reported on is just the thing, but another may point out that good public relations or present market conditions make it prohibitive. Sometimes the discussions prove so interesting that other reports must be postponed until the subsequent meeting.

From the pharmacist, the members learn the latest drugs on the market, the sources of the drugs, and other items of note concerning them. The dietitian may report on a new treatment for diabetes, food costs, or ways of economizing. The purchasing agent may keep the club posted on new inventions, price changes (advances for the most part!), and the difficulty of procuring certain items. No one, however, is confined to reporting on things pertaining to his particular department. The only requirement is that the articles be of general interest and value to all.

Each member reporting submits a summary of the article with his comments neatly typewritten on a 4 by 8 inch file card. These cards are kept on file in the administrator's office; the summaries are available at all times to the members for reference purposes.

Since its inception, the journal club has grown steadily, and there is not a member who would voluntarily miss a meeting. Starting with nine pioneers, the club now numbers twenty-two regular members and includes many of the clinical instructors and administrative personnel. It has proved an excellent training source for our intern administrators.

I feel that the journal club has paid large dividends for the time spent on it, and I look upon it as an indispensable tool. Tangible outcomes have been the publication of a personnel bulletin, the *Providence Reporter,* the inauguration of "Cook's Tours" for new personnel, the issuing of a weekly nurses' bulletin, which notifies the nursing staff of changes in policy and procedures or calls attention to items that need to be checked.

Less tangible, but even more important are the following journal club fruits:

1. It helps to keep the personnel informed of the latest developments in the hospital field.
2. It promotes good personnel and public relations.
3. It stimulates effective thinking in the interest of better care for the patient.

Comparatively new in hospital circles, the experiment is voted a tremendous success by all who participate in it.

GEORGE WASHINGTON

HARRY HEWES
Information Officer
Federal Works Agency

RISING six white limestone stories opposite historic Washington Circle in the nation's capital, George Washington University Hospital occupies a city square with its main entrance on 23rd Street, N. W., the ambulance and service entrances on Eye Street, doctors' entrance on 22nd, and the outpatient department entrance facing the Circle.

COMFORT IS EMPHASIZED

Its patients' beds are in 120 single and 108 double rooms and eighteen wards. It also provides forty beds for resident physicians and interns. There are six air-conditioned major and three smaller operating rooms, nine air-conditioned delivery and labor rooms, nurseries, and all other departments and facilities for a fully equipped acute general hospital. Noise abatement devices, motion picture equipment for recording of operating technics, and color schemes selected for therapeutic value are among the installations.

Dr. Cloyd Heck Marvin, president of the university, has emphasized that the new hospital is primarily a research center and that a large amount of its space is devoted to laboratories and research units.

"A hospital should be equipped to deliver a baby or operate on an appendix, and also, perhaps, to find a cure for mankind's most fearsome killers," he said. "If that can be carried on under one roof, our idea for a general medical center will be a success."

Started as a public works project under the Lanham Act during the war and built by the Public Buildings Administration of the Federal Works Agency, the outlay per patient bed, estimated on basic cost, was $10,000.

Plans and specifications were prepared by Faulkner, Kingsbury and Stenhouse, Washington architects. The hospital building is 400 feet long and, at its wing projections, 185 feet in width, with a floor area of 240,000 square feet.

Construction is of reinforced concrete frame on reinforced spread footings. Exterior walls are of Indiana limestone backed with brick. The floors are of reinforced rib slab construction with partitions of clay tile. The entrance lobby is finished with travertine marble on both walls and floor; corridors and bedrooms have linoleum floor covering. In operating and delivery rooms there are terrazzo floors, and the x-ray wing and all laboratories and similar spaces have asphalt tile covering. There are four passenger elevators and one freight elevator and three dumb-waiters. The building has 1374 windows.

TEMPEST OVER SITE

Work of clearing the hospital site of the many homes, an apartment building, and St. Paul's Episcopal Church, an edifice built seventy-five years before, started early in 1945. Some of the homeowners, faced with the housing shortage in the District, and vestrymen and parishioners of St. Paul's strenuously opposed the new project. The courts upheld the condemnation order, however, until finally only one person, a retired Episcopal clergyman, remained in his home on Eye Street, and a court order was required for his eviction. F.W.A. carefully stored the altar, organ, stained glass windows and other memorials from the church until another structure is built; in the meantime the university made its auditorium available for its services.

The Washington Circle site for the teaching hospital was in line with plans of the university dating back to 1928, when it was felt the school had to determine for all time where its location would be. After a careful survey of universities in Europe and America and a study of comparative needs, it was decided to develop George Washington University in the area between Pennsylvania Avenue, New Hampshire Avenue, F Street, 19th Street and the Potomac River. This is approximately the area chosen by l'Enfant and Washington for the "College" mentioned in the will of the first President. The National Capital Park and Planning Commission certified this plan in 1929 and restated its approval in the spring of 1944.

MORE THAN CENTURY OLD

George Washington University Hospital has a 104 year old history dating to 1844, when the faculty of the medical school—then a part of Columbian College—"ever cognizant of the value of clinical training," the historic note reads, petitioned Congress for the use of the Washington Infirmary in Judiciary Square. Thus, this became one of the earliest teaching hospitals in the country.

The ancient building had been acquired by Congress in 1806 as a poorhouse, and later it served as a jail. Congress appropriated a small amount annually for the treatment of transient sick paupers, and Sisters of Charity provided the nursing. With the outbreak of the War Between the States in 1861 the building reverted to government control. Six months later it was destroyed by fire.

In 1867 W. W. Corcoran donated a building on H Street, the site of the present medical school, and an adjacent parcel of ground. The "old" university hospital on that site dates to 1897.

UNIVERSITY HOSPITAL

L. G. SCHMELZER
Superintendent
George Washington University Hospital

THE new George Washington University Hospital is characterized by a modern, simplified type of architecture. This is in keeping with the general motif and architectural character of the newer buildings on the university campus. While stress has been placed upon practical utility and hospital service rather than on monumental effect, the exterior appearance is something of which we can well be proud. The main framework is made up of reinforced concrete which is considered by modern engineers to be the most generally satisfactory material for a horizontal type of hospital of this size. The exceptions to this are the elevator shafts, the large staff conference room, and the entrances—which must, obviously, be of structural steel.

Much time and study were devoted to orientation, that is, the selection of a building shape and contour which would best be adapted to the site. The design used is that of a large letter "H" to which is affixed at one end a smaller letter "H." This is ideal in that it allows a maximum of air and light exposure for patients' rooms. The large "H" which extends toward the south contains the patients' bedrooms. The small "H' which extends toward the north is devoted primarily to *service,* such as the outpatient department, operating rooms, and delivery rooms. This portion of the building is seven stories high, including the ground floor.

The hospital has been planned in units of service, that is, all rooms for any specific unit are grouped together and so arranged as to facilitate coordination. For example, each floor is devoted to a special type of service, *i.e.* the second floor to patients who are confined for medical and diagnostic purposes, the third floor to obstetrical patients, the fourth floor to general surgery, the fifth floor to specialty surgery, and the sixth floor divided equally between the psychiatry and neurological services. Each of these departments is furnished with the most modern scientific apparatus and equipment essential to specialized medical and surgical treatment of the patients.

Patients are accommodated in private rooms, semiprivate rooms, or wards. Every floor is provided with these varied accommodations so that regardless of the nature of the patient's illness or the service on which he is cared for, he is permitted to have some latitude in the selection of a room. Hot and cold running water is available in every patient's room.

During recent years especially, hospitals have been faced with the problem of keeping pace with the rapid developments in the field of scientific medicine. This new facility embodies all of the features essential to extending the best, most up-to-the-minute scientific care to patients.

CONSTRUCTION DETAILS

COST: New building and equipment represent an overall investment of approximately $4,500,000 (including acquisition of the site) and to replace it at this time would cost in the neighborhood of $6,000,000.

OVERALL MEASUREMENTS: Length, approximately 400 feet. Width at wing projections, approximately 185 feet.

FLOOR AREA: Approximately 240,000 square feet.

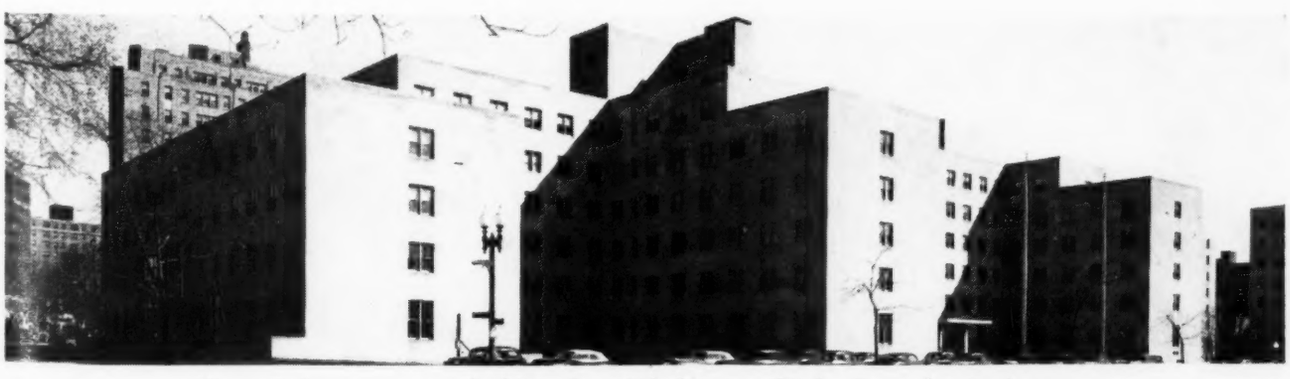
SPACE CONTENTS: Approximately 3,000,000 cubic feet.

HEIGHT: Seven stories, including ground floor.

WIDTH OF CORRIDORS: 8 feet.

NUMBER OF WINDOWS: 1374.

HEIGHT OF CEILINGS (patients' floors): 10 feet to 10 feet 6 inches.



View of the seven-story building from Washington Circle, Pennsylvania Avenue.

CONSTRUCTION DETAILS, Cont.

FLOOR EQUIVALENT: Area devoted to service, patients' rooms, and corridors equivalent to the street space of approximately seven city blocks.

NUMBER OF PATIENTS' ROOMS: 243.

NUMBER OF PATIENT BEDS: Normal—405.

Recapitulation:	Rooms	Beds
8 bed wards	3	24
4 bed wards	10	40
2 bed rooms*	111	222
Private rooms (with bath)	34	34
Private rooms (without bath)	85	85
	243	405

*Indicates maximum utility. In some instances these 2 bed rooms will be used for one bed only.

NUMBER OF ELEVATORS: 5 (4 passenger and 1 service). All high speed, fully automatic, and of sufficient size to accommodate a standard sized hospital bed.

NUMBER OF DUMB-WAITERS: 3 (2 extending from special diet kitchen on ground floor to pantry on every floor; 1 extending from pharmacy in basement to every floor).

AIR CONDITIONING UNITS (providing complete air conditioning throughout the year): Entire operating room pavilion; entire delivery room pavilion; premature nursery; one patient's room on each floor; two patients' rooms on sixth floor; gymnasium and electroencephalography room in neurosurgery section on sixth floor.

WASH BOWLS, HOT AND COLD WATER SUPPLY: Every patient's room equipped with wash bowl and hot and cold water supply.

EQUIPMENT ON PATIENTS' FLOOR: 1 Nurses' Station for approximately every 24 patients. Each station has a clothes closet, toilet, medicine cabinet, with sink and locked narcotic box (which if left unlocked will not permit the outer door to be closed), charting desk, and chart rack. Nurses' stations located strategically at the center of each nursing unit and near the elevators to command full view of corridors, visitors' waiting alcove, and signal lights above each patient's door.

Bedpan Rooms centrally located.

1 Laboratory for medical students.

2 Linen Chutes and 1 Trash Chute.

1 Interns' Room.

1 Rest Room for nurses.

1 Large Pantry or Diet Kitchen.

1 or 2 Utility Suites (as necessary), each consisting of a bedpan room, flower room, bathroom and linen closet.

3 or 4 Standard Utility Rooms (as necessary), each divided into one soiled and one clean section.

DOCTORS' IN AND OUT REGISTER: 3 panels, each having a capacity for the names of 200 doctors. One located at outpatient department entrance, one in center portion of the building, and one at telephone switchboard.

DOCTORS' CALL SYSTEM: A controlled speaker strategically located near each nurses' station and out of the range of patients' rooms.

NURSES' SIGNAL SYSTEM: Dome light at each patient's room or ward as well as a light panel at each nurses' station to indicate which patient is signaling for nursing service.

SYNCHRONIZED ELECTRIC CLOCK SYSTEM: Installed throughout the hospital so that appointments for various services can be scheduled with uniformity among the departments. Operating and delivery room clocks equipped with interval timers and sweep second hands so that patients' reactions can be observed and recorded accurately.

EMERGENCY LIGHTING SYSTEM: Special storage battery lighting system provides current for the operating rooms and delivery rooms. In most hospitals, such systems ordinarily require plugging in or connecting a special fixture designed for this purpose. However, in our new hospital, lighting fixtures in these rooms are provided with a dual wiring system so that emergency battery current will cut in automatically the instant that the regular lighting current fails. In addition, all hallways, stairways and exit lights are supplied with electric current from the emergency system for the district rather than through the standard system.

MOVING PICTURES: Operating and delivery rooms wired for moving pictures, the first hospital in Washington to be provided with this facility.

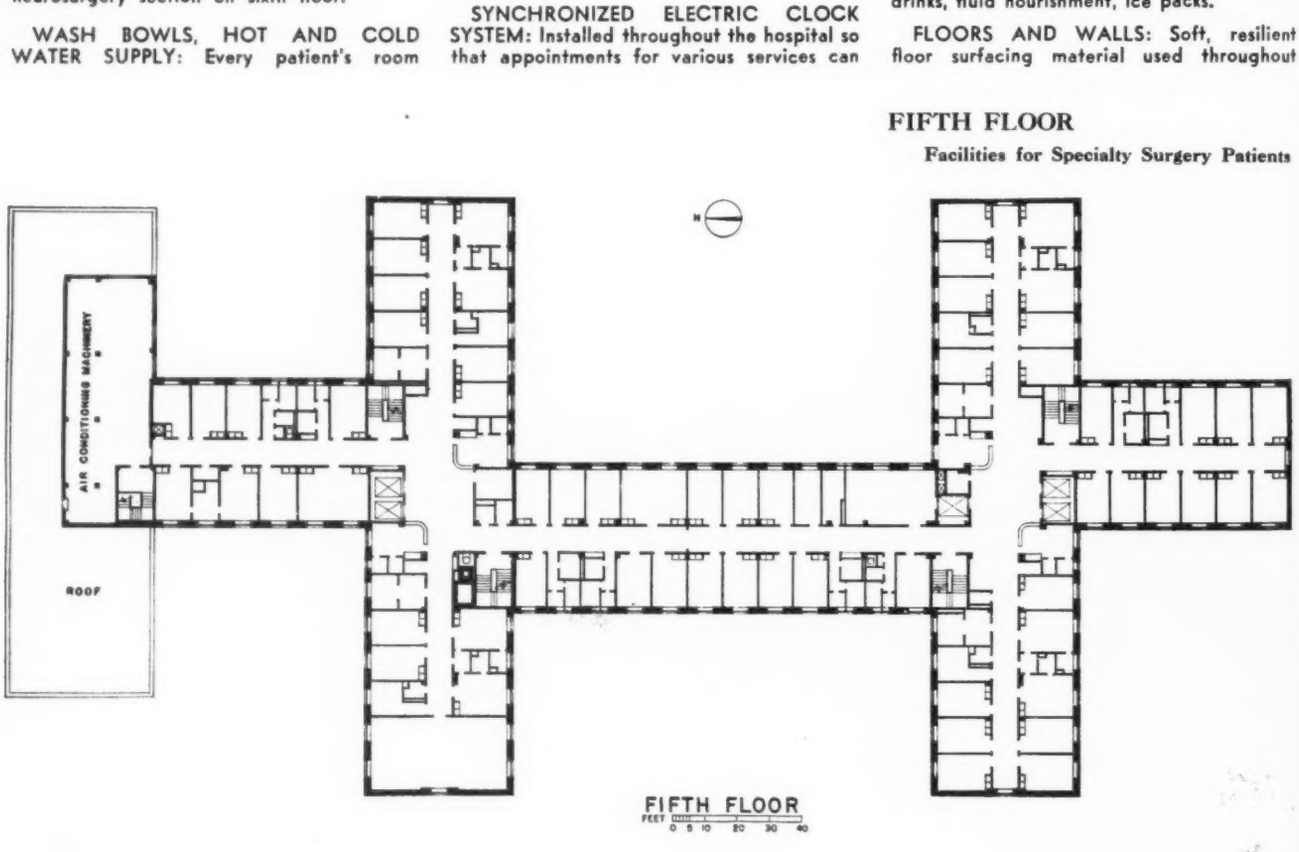
PIPED IN OXYGEN SYSTEM: Installed in premature nursery. A depot or storage room for oxygen tanks located outside of the nursery, thus eliminating the necessity for nonnursing personnel to enter the nursery itself. This pipe line extends to each nursery unit in the premature nursery, and an oxygen outlet is available for rapid connection with the infants' incubators by the nurse on duty at this department.

ICE MACHINE: The hospital manufactures its own ice by means of a 6 ton capacity ice machine. This unit produces shaved ice rather than ice cubes and provides an ample supply of ice for cold drinks, fluid nourishment, ice packs.

FLOORS AND WALLS: Soft, resilient floor surfacing material used throughout

FIFTH FLOOR

Facilities for Specialty Surgery Patients



Gynecology Bed Patients
Ophthalmology Bed Patients
Flower Rooms

Visitors' Alcove
Student Laboratory
Internes' Rooms

Nurses' Room
Nurses' Stations

Pantry
Utility Room

This typical nurses' station is so located as to command a view down the long hospital corridors.

Doctors register just off the entrance lobby and within easy sight of the telephone switchboard.

the areas where patients' rooms are located thus further reducing the noise problem as well as adding to the efficiency of personnel.

Tile used in certain rooms and departments where sanitation and utility are paramount. Colorful ceramic wall tile has been installed in the following places: ivory wainscot in outpatient department rooms, and corridors; light green in delivery rooms, operating rooms, and treatment rooms; pale green in utility rooms, bedpan rooms, bathrooms. Colored quarry tile as well as terrazzo also used on the floors in some of the service rooms which do not proximate the rooms of patients and where the nature of the service requires a hard surface.

SPECIAL FEATURES

ANIMAL ROOM: Provided on roof of hospital for making important laboratory tests through animal injection as an aid to diagnoses.

OPTICAL SHOP: A complete optical shop provided in the ophthalmology department wherein a patient may have his eyes tested and refracted, lenses prescribed and ground, and glasses fitted within the confines of the hospital. This department also has a special section devoted to what is known as orthopics. This involves the use of expensive apparatus or equipment by trained technicians in giving special muscle training and exercises in order to overcome certain defects and conditions of the eyes.

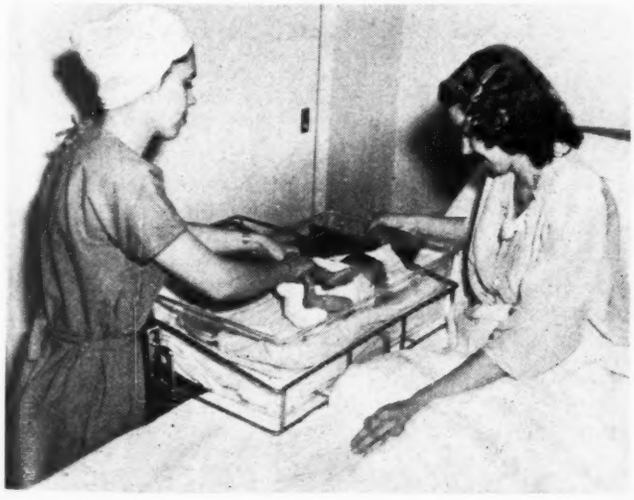
COLOR: In keeping with other scientific advancements in the medical field, the use of color in patients' rooms and furnishings takes on new significance in our new hospital. Color psychologists have been consulted and the color scheme has been applied in such manner as to be of definite psychological and physiological value to both the patients and personnel. Six basic colors have been used, the lighter tints being applied where there is more exposure to sunlight. The pleasant atmosphere of color in the hospital not only tends to speed the recovery of the sick but also should increase the efficiency of the medical and nursing staffs.

NOISE: Noise is a disturbing factor in any hospital, and we have done everything possible to combat this problem. Although outside noises are often mentioned as a source of complaint, noises from within the hospital, in my twenty-two years of experience in the hospital field, have been a chief source of complaint. The latest and best acoustical materials have been used in corridors, utility rooms, diet kitchens, and other areas from which noise usually emanates. Quiet floor surfacing materials are used throughout sections where patients' rooms are located. Receding roof lines and shape and design of hospital building tend to reduce to a minimum re-echoing of street and traffic noises.

RADIOLOGY DEPARTMENT: A complete and well balanced department has been made available for this important phase of hospital service. The latest and most modern type of x-ray apparatus designed for both diagnostic and x-ray therapy procedures has been installed. The equipment consists of:

1 250 KV Deep X-ray Therapy Unit.
1 Superficial Therapy Unit—120 KV.
2 Radiographic Fluoroscopic Units, complete with tilt table. One of these units equipped with a miniature chest unit, 70 mm, for use with 4 by 10 film reduced to 4 by 5; 1 unit equipped with a laminographic attachment.
2 Mobile Units.
1 Dental Unit (in the Dental Surgery Section).
1 Superficial X-Ray Therapy Unit, 120 KV (for use in Dermatology Section).
1 Vertical Fluoroscope (for use at the Heart Station in the Cardiology Department).
2 Genito-Urological Units for Cystoscopy Rooms.

(Cont. on next page.)



Plastic bassinet, which may be attached to the mother's bed, is mounted on cabinet on wheels.

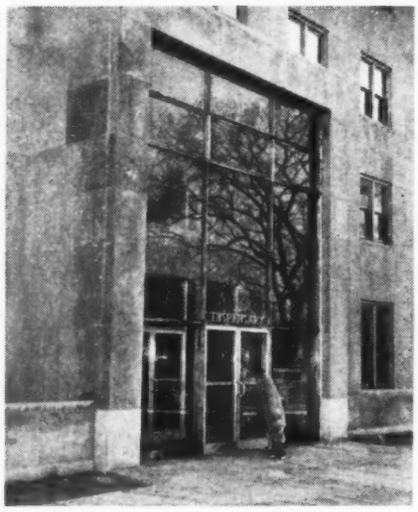
Typical of the diet kitchens. This particular one serves the maternity section on third floor.

Infant can have individual cubicle.

Two double rooms face nursery.

One of the five labor rooms.

Dining room for hospital personnel.



Impressive entrance to dispensary.

Three graduate nurses inspect the Everglades Apartments, 2223 H Street, N.W., being used as a nurses' residence. They are Mary Elizabeth Berry, graduate of Norwood Hospital, Berlin, Ala.; Claire Zientek, graduate of Mercy Hospital, Wilkes-Barre, Pa., and Louise Wooten of Macon (Ga.) Hospital.

Radiology Department, Cont.

All of the equipment is of the latest design and completely shockproofed to provide maximum protection for patients and technicians.

LABORATORIES: One of the most important phases of hospital service is the laboratories. Provision has been made for every conceivable type of examination, including routine urine, blood, blood chemistry, and other special examinations. A complete facility for the examination of tissues provided in the pathology section.

MATERNITY DEPARTMENT: Probably one of the most revolutionary departures in the history of hospital architectural arrangement and planning for a maternity department is reflected in our new hospital. The theory of this plan, as advanced by Doctors Parks and McLendon of our hospital staff and medical school faculty, is one in which the hospital gives proper recognition to the newborn infant as being a full-fledged patient. For years hospitals have been giving primary consideration to the mother, and the child has been handled more or less as a "by-product" as far as the nursery arrangement and architectural planning are concerned.

I do not mean to convey that the child has been neglected from a medical standpoint; rather he has ordinarily been placed in a large nursery with many other babies, with the room electrically illuminated in full force, with diaper changes regularly, as necessary, and removed to and from the mother's room rather mechanically at feeding periods.

With this new plan all infants are confined at least in individual cubicle nurseries. In addition, some of them are cared for in a totally separate room of their own located next to the mother's room with glass vision panel between. Others have a private nursery-room within the confines of the mother's room. These varied facilities permit the mother to exercise virtually as much choice in the selection of a nursery for her baby as she does in the selection of her own room. The nurseries thus become the centers around which the mothers' rooms are planned.

The cubicled or group nursery is of 4 or 8 crib capacity. The 4 crib nursery is divided with 2 cribs on each side and located next to 2 bed rooms for mothers, with glass vision panels between so that the mother or the nurse can see the child from the mother's room.

The 8 crib nurseries are equipped with glass vision panels along the corridor wall so that they are in full view of the nurses at all times. These group nursery facilities consist of a chart room and examination or treatment room as one working unit.

In addition there are suspect nurseries for infants who are ill from infection and require isolation. There are also suspect bedrooms for mothers who are ill and require isolation.

A premature nursery which is fully air conditioned and equipped with every modern facility necessary for their care is also provided. All cribs or bassinets in the maternity department are of special design that permits their being wheeled into the mother's room and attached to her bed. The child spends more time with the mother than has been the practice in the past. The idea in this case is to provide a closer mother-child relationship during the early stages of infancy.

It is believed that this new arrangement:

1. Affords better control of nursery infections through the use of the small functional unit.

2. Reduces the number of epidemics of impetigo, respiratory infections, and more particularly neonatal diarrhea.

3. Permits strict segregation of infants showing the earliest signs of infection.

4. Permits the department to serve as a maternal center of education through instruction extended to the mothers by the nursing personnel.

HOSPITAL DAYS CAN BE HAPPY DAYS FOR THE CHILD

MILDRED WALTON
University Hospital, Ann Arbor, Mich.

MORE than a million children are admitted to hospitals each year for varying periods. What happens to the child during this interval and what can be done to help him become as nearly normal as possible is a matter for each hospital director to consider carefully.

The need for a complete program of service, education and recreation, and research to improve that program, for both adults and children, was recognized by Dorothy Ketchum twenty-five years ago at the University Hospital, Ann Arbor, Mich., when she developed four units as a part of the social service department to work together in offering the essentials for normal development of patients. These units are medical case work, occupational therapy, library and the University Hospital school, which includes recreation. Together, they reach 93 per cent of all patients admitted to the hospital yearly.

NO VACATION FROM ILLNESS

The University Hospital school reaches a total of 4500 or more acutely ill children yearly. These children come from the eighty-three counties of the state, and some from out of state. They range in age from fifteen months through high school and present a wide variety of diagnoses with varying degrees of incapacity. The school runs for twelve months because there is no vacation from illness, and we feel that it is necessary in an acute general hospital to maintain a program for six days a week and fifty-two weeks a year.

The program is planned to fulfill the needs of the whole child and it must be integrated around the hospital routine and the medical program set up for each child. The basic needs of an ill or crippled child are much the same as those of well children except for some additional needs and more emphasis on specific ones. The hospitalized child has need for normal experiences of life to combat the isolation that illness inflicts. These include social contacts every day, home experiences and contacts with the outside world. The young patient has the usual emotional needs in addition to special ones for reassurance, security and freedom from fear.

The needs for creative expression of the sick child are perhaps greater than are those for the normal youngster, since through creative accomplishments he gains a sense of worth and growth. Cultural or esthetic needs are emphasized for the long-term patient because of the meagerness of his surroundings. As is true of the well child, the ill and crippled one needs to experience a definite intellectual growth.

Research results have shown that a well balanced activity program will free the youngster from emotional strain; bring better understanding between child and adult, and develop a feeling of pride in accomplishment, a tolerant understanding, power to concentrate, and a spirit of helpfulness.

In the light of the needs of all children and the expected results to be obtained from a well planned program of activity, the daily program for the hospital child has been developed.

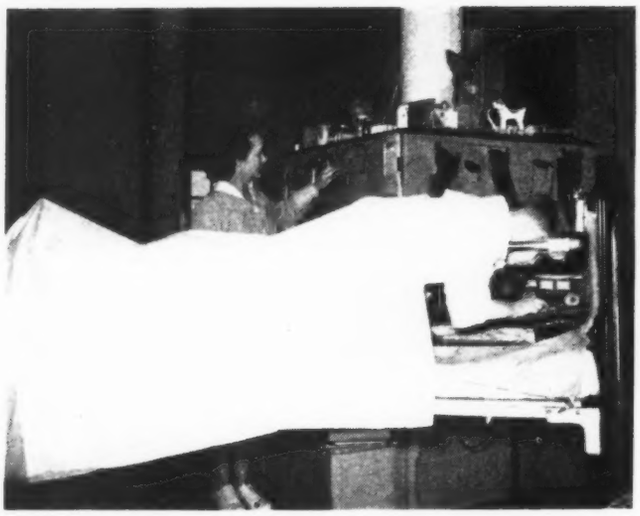
Let us skip the necessary morning care essential to every hospital patient and visit the children's floor with Virginia, the nurse's aide, whose responsibilities include transportation of children from wards to the roof playground. She is greeted enthusiastically with cries of "I'm ready, take me first," or "I'll be ready next trip," or "Please comb my hair and I'll be ready." With fine impartiality, Virginia selects her charges in turns and the elevators are loaded for a trip to the roof.

The roof is a center of seething activity for both adults and children, far away from the treatment units so that there is no resemblance to hospital routine. No treatment is given here. Patients come to the roof in beds, in wheel chairs, and on foot. Here they are literally transferred to a fairyland of color, equipment and variety of ac-activities, with skilled instructors to direct their program. Part of the area is enclosed and part is not. Here the four freedoms, on which the philosophy of the social service department evolves, reign supreme—freedom for learning, freedom for expression, freedom for choice, and freedom for fun.

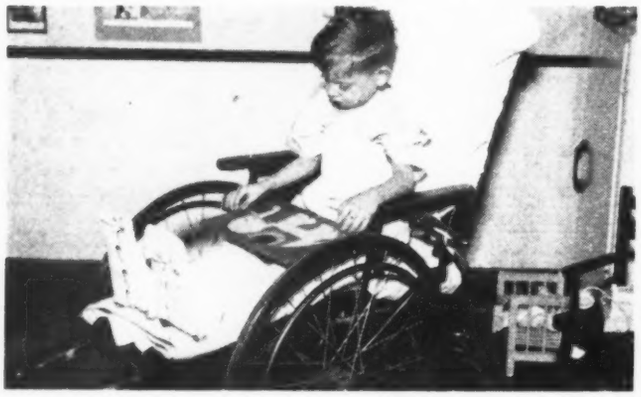
DAY STARTS WITH PLAY

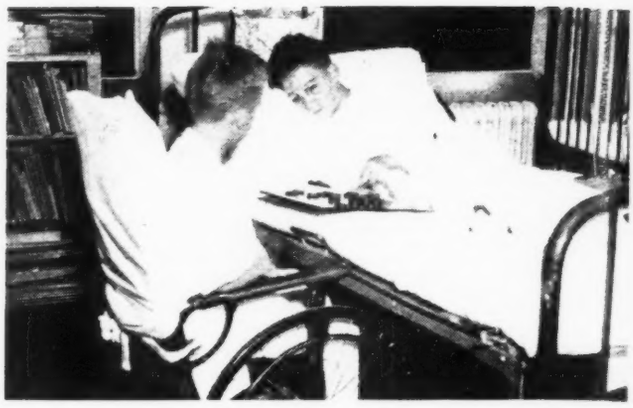
The program usually starts with a short period of free play in the morning. Newcomers to the hospital look around investigating the equipment, or if the newcomer is confined to bed, many different toys and games are brought to his bed for his examination. The old-timers, who include those who have been in attendance at least once, waste no time in choosing their toys and soon the playroom or outside roof, depending on the time of year and weather, hums with busy, happy activity.

This period gives the teacher an opportunity to help children who need social adjustment, to help retarded children in selection and use of toys, and restless boys and girls in increasing their span of attention by teaching them how to get the maximum use of toys and materials. After the period of free play all primary grade children gather around a large, low table in front of the blackboard. Beds and wheel chairs are placed in the background and the school program occupies the remainder of the morning. Boys and girls above the fourth grade go to the schoolroom on the eighth floor. The preschool group is given toys and activities on its own level. The school program must of neces-



Above: Boy making gift on the jig-saw in the craft shop. Below: At work on elephant puzzle.





Above: A checker game is in progress in the playroom. Below: Stories for preschool group.

sity be flexible and includes individual instruction, children helping each other, independent work, and group instruction and projects. Much of the reading instruction is given through group projects planned around a central interest. At least once a week a short educational film is shown. This forms an excellent basis for reading, spelling, social study, sometimes music and art, and often arithmetic.

CHILD FEELS MORE SECURE

Regular attendance in school gives the hospitalized child a needed sense of security and a feeling of growth. It helps to identify him with his own home school and aids eventually in his adjustment on return to that school. At 11 o'clock the patients are taken back to their floor for lunches and naps.

At 2 o'clock the children are again brought to the roof. Those between the ages of 8 and 14 may go to the craft shop if they wish. This is entirely their choice. The first part of the afternoon is occupied with child initiated activity, with teacher encouragement for group play. During this time there is usually soft background music on the record player.

The last half of the afternoon, boys and girls, regardless of age, participate in some group project. This may be a story told by the teacher, a musical story played on the record player, rhythm band, learning a new song, art activity such as finger painting, bubble blowing, puppet plays or other little plays or programs, magic shows, special day parties, and craft projects.

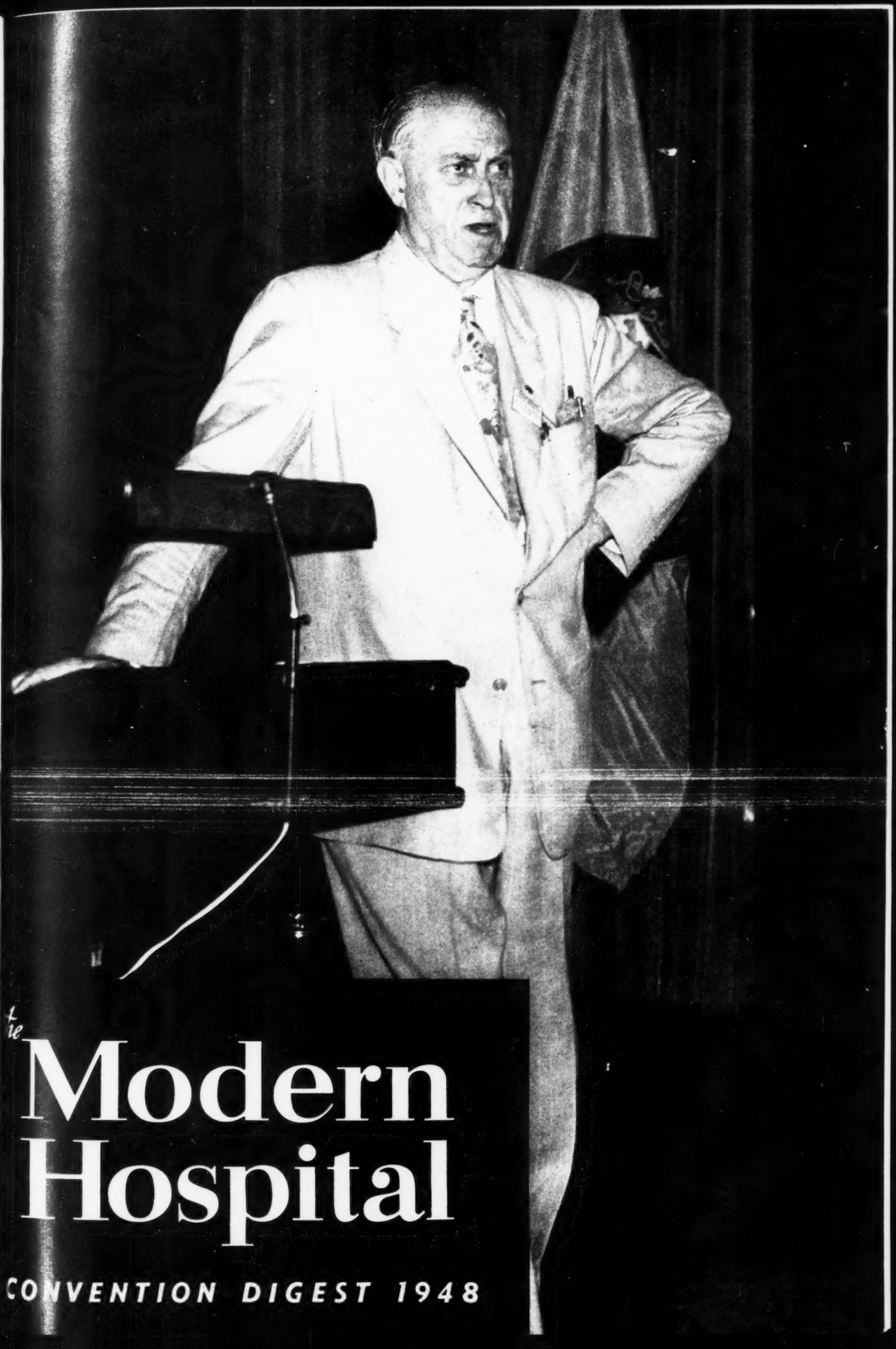
All children and most adults like to have opportunity for creative expression. Our children learn to do many things while they are hospitalized. Simple projects that can be initiated and completed in two or three days have been found to be most satisfactory because of the relatively short hospitalization of most patients.

At 4 o'clock all are taken back to their floors where preparation for the evening meal and night begins immediately. The children, who because of their physical condition or medical treatment were unable to go to the roof, have been reached in their wards and rooms by teachers who present as near an approximation of the roof program as is possible.

Good equipment for such a program is necessary but equipment or space is of little worth to the child without trained and understanding teachers for guidance. The selection and training of teachers for sick children are of the utmost importance. While a good teacher gives the impression that her work is easy, that the children are independent of her, and that any strong adult can do the work, we have only to observe a group of children with an untrained or unskilled person in charge to recognize how important skill and training are.

Teachers must be sensitive to individual needs, quick to give the new child confidence, and able to teach the self-confidence and self-discipline that he needs.

The keynote of the day is to let the child do things for himself, to have a chance to think, plan, work and play so that at the end of the day he feels a sense of accomplishment and a healthy anticipation of the morrow.



The Modern Hospital

CONVENTION DIGEST 1948

Delegates line up to get credentials for opening meeting of the House.

Harps in the Morning

IGNORING the admonition of Aristotle, who said that the work of the harp-player is to play upon the harp, the nation's hospital administrators spent only a fraction of their 50th anniversary convention examining problems of hospital administration. For a good half of the time they were looking outward at their relationships with other elements of the community, as a harp-player might who realized that not his performance alone, but the whole orchestra's, made the music that satisfied the public taste.

In their morning sessions, the assembled administrators dutifully plucked at their harps, engaging in lively and illuminating, if not always conclusive, discussions of such administrative disharmonies as control of surgery, specialists' contracts, construction, Blue Cross, ward rates and practical nurses. Afternoons, they listened attentively to guest conductors from business and industry, science, education, government and medicine.

Before, between and after these serious concerts, they played in the circus band, attending grand openings, dedications, inductions and receptions, taking boat-rides to and from a Navy hospital ship anchored conveniently off-shore, promenading, gossiping and trying to get nourished for something less than $5 a meal. This was a major problem the week of September 20 in fabulous Atlantic City, which consists largely of

CONVENTION DIGEST

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Prepared by:

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EVERETT W. JONES

hotels, tourists' homes, taxicabs, bar and grills, souvenir stands, neon signs, bingo games, rolling chairs and the Atlantic Ocean, in which visitors are graciously permitted to swim for only 75 cents.

Convention conversation this year included a couple of subjects that were brand new to the younger generation of administrators: empty beds and idle help. "This business of sending patients home with their stitches in is beginning to hurt," said one administrator whose hospital no longer bulges. "Lately, I've been stopping doctors in the hall and suggesting that they keep their patients in another day," he added.

Lobby talk also indicated that in some hospitals, at any rate, the end of the labor famine is in sight. "I advertised for a waitress and had eight applications," an administrator related, still wondering how it could have happened. "Always before when I ran an ad, if I had a reply from one girl I'd hop in the car and go pick her up while she still wanted the job."

If these signs could be believed, the 50th anniversary convention may have marked the end of an era. From now on, the harps might play a different tune.

In Business

The 50th anniversary meeting of the American Hospital Association's House of Delegates opened Sunday morning, September 19, with President Graham Davis making the astonishing prediction that the word hospital may disappear from our vocabularies during the next fifty years — to be supplanted, presumably, by some term, such as health center, which will more accurately describe the expanded activities and responsibilities of tomorrow's institutions. Mr. Davis polished off his introductory remarks with appropriate bows to the past and the future and a fast shaft for Federal Security Administrator Oscar Ewing, who, he said, "shows little confidence in our free enterprise system." After that, the delegates settled down to hear some reports and resolve some resolutions.

JOHN N. HATFIELD, administrator of the Pennsylvania Hospital in Philadelphia, was named president-elect of the association at the House of Delegates meeting September 22. Mr. Hatfield for several years has served the association as chairman of the council on government relations. (For news of other officers, see page 8.)

The most important of these resolutions put them in the insurance business in a big way. Following presentation of a report by Blue Cross Commission chairman J. Douglas Colman of Baltimore, and a brief discussion, the House approved formation of the proposed Blue Cross-Blue Shield Association and its stock insurance company offspring, Blue Cross-Blue Shield Health Service, Inc., which will write indemnity contracts to cover benefits not included in local Blue Cross and Blue Shield plans, so that national employers may offer uniform coverage to employes in all parts of the country.

The proposal had previously been approved by the association's council on prepayment plans and hospital reimbursement, by the board of trustees and, after considerable discussion, by the coordinating committee. It still needed action by the local Blue Cross and Blue Shield plans, which would put up the money to get it started.

"This approval doesn't commit the plans, of course," said Dr. Paul R. Hawley, who had worked mightily to achieve it and was the man who would now have most to do with making it work. "Some of the plans may stay out, but as soon as twelve or fifteen of the larger ones sign up we're in business." Earlier, Dr. Hawley had earnestly urged the delegates to approve the proposal. "Those who want government medicine are saying that voluntary plans can't do the job," he warned. "As presently organized, they can't. Properly organized, voluntary plans can do the job better than the government can."

That statement from Dr. Hawley drew the only spontaneous applause of the day.

In two other significant moves, the delegates nodded yes on a commission-type study of hospital finance and a slick-type advertising campaign aimed at making people feel better about hospitals. The finance study will be conducted by an inde-

Father John W. Barrett, of Chicago; Ray Kneifl, St. Louis; Father George L. Smith.

B. Tol Terrell, now at San Angelo, Tex., chats with Florence King of St. Louis.

Albert Whitehall of the A.H.A. and the President-elect, John N. Hatfield.

Left: Dr. Edwin L. Harmon, Dr. Frank Bradley, Arthur J. Sullivan and Dr. Anthony J. J. Rourke. Right: Dr. Otis L. Whitecotton, Norman Bailey, H. Robert Haupt and E. Elwin Glover.

pendent commission to be appointed by a special committee of the board of trustees suggested by the council on prepayment plans. The commission's work will be largely financed by foundation grants and is expected to take two years. In presenting its report prior to asking approval of the project, the council introduced a detailed statement of the purposes of the study, which was freely translated by one observer to mean, "What gives with the money?"

The public relations program will be an extension to broader fields of this year's nurse recruitment campaign, it was explained. With the help of the Advertising Council, which will contribute the talent, the program will seek to "relate the vital place of the hospital to the welfare of the individual and to the community and bring about needed public understanding and support of all hospitals," according to the report of the council on public relations. Estimated cost of doing all this: $100,000, of which $60,000 is to be contributed by hospitals.

Waltz Time

In their final meeting Wednesday evening of convention week, association delegates were plagued by a public address system whose capriciousness made it easier at times to hear the string orchestra in the dining room next door than it was to hear the reports and recommendations of the officers. As one delegate observed, it was the first time the House had ever passed resolutions in waltz time.

One resolution almost didn't pass at all. Introduced by Chairman Buerki of the council on professional practice, this was a recommended "statement of hospital aims for community relations"—an attempt to summarize what a hospital is and does. The idea, as Dr. Buerki explained it, was to publicize the statement as widely as possible; the council felt it would help hospitals win public understanding in their communities.

The delegates, however, were not so sure. First doubt was expressed by Stanley Howe of New Jersey, who singled out a sentence or two that looked to him like "needling certain professions" when it would be wiser, he thought, to emphasize the contribution made by loyal workers. Dr. Harvey Agnew of Toronto saw dynamite in the admission that "there are still far too many patients who complain of lack of interest of hospital personnel in their needs." Carl Flath of Hawaii didn't like repetition of the phrase "in the face of almost insurmountable difficulties," which appeared twice in the statement and sounded a little thick to him. Another delegate wanted to know what "hospital concepts" were.

The Association named Cleveland as its 1949 convention city.

On a show of hands, most of the delegates wanted some revisions made in the statement before it was released. This apparently unexpected resistance threw the meeting into a parliamentary tangle which was unraveled, after twenty minutes, by a trusting motion to let the council redraft the statement and release it without resubmitting it to the House for approval.

The motion carried, and the delegates promptly picked up another hot potato—internships. Speaking for the council, Dr. Buerki acknowledged that last year's plan for the appointment of interns had not been uniformly satisfactory. It was felt, however, that 85 per cent of hospitals had cooperated in the plan, and the council recommended its adoption for the coming year, with minor changes to permit the applicant to draw a deep breath before accepting an offered appointment. With 9118 internships and 5716 interns, Dr. Buerki pointed out, no plan was going to work to perfection.

After a few minutes of desultory discussion, Dr. Donald C. Smelzer of Philadelphia peeled off. "It's a lousy program," he declared. "It might work if all hospitals were honest, but they aren't. Some hospitals cheat, and the program breaks down. It makes the boys dishonest too."

Scattered applause from the floor indicated that some delegates agreed with Dr. Smelzer, but nobody else spoke on his side, and a little while later the delegates let it pass by voting acceptance of the council report. Before leaving professional practice behind, however, the House heard a resolution describing the point rating system of the American College of Surgeons as a "helpful tool for self-appraisal by any hospital," recommending its use by hospitals, and urging member in-

stitutions to meet A.C.S. minimum standards. Delegates approved the resolution enthusiastically and added a round of applause for Dr. MacEachern, who was present and pleased.

Recommendations and resolutions brought in by other councils rolled without squeaking. The council on association relations wanted a change in the by-laws governing certain types of memberships, and got it. The council on planning and plant operation was opposed to hospital accidents and fires, and so were the delegates. Dr. M. F. Steele of Cincinnati wanted the 1939 principles of relationship between hospitals and radiologists (fair financial arrangement, nobody exploits anybody, patient gets breaks) reaffirmed, and they were. The committee on resolutions regretted deaths, thanked exhibitors, appreciated hotel and convention hall accommodations, and urged hospitals to request the services of professional displaced persons from abroad.

Then the new officers were introduced and applauded. President-elect Hatfield made one of the shortest speeches on record in organized society—his first official act, and a good one—and that was the meeting.

Which Drawer?

Like a football team that is ready to run with the ball but can't find it, the convention agreed that the auxiliary nursing worker is here to stay and then wondered who she is and where to put her. Scheduled speakers charged at the question from all sides: Blanche Pfefferkorn of New York summarized the results of her recent study showing that various types of auxiliary workers can lift different pieces of the whole nursing burden, as a man might move a heavy chest by taking the drawers out and giving them to his children to carry—top drawers to the littlest child, heavier ones for the older youngsters, and so on. Miss Pfefferkorn and Mildred Riese of Detroit pointed out, however, that graduate nurse time is used guiding and helping auxiliaries, a loss that must be charged against any gain that has resulted.

Dr. Herbert M. Wortman of Mountainside Hospital, Montclair, N. J., doubted that there would be any gain in the first place, claiming that it cost less to run his hospital with an all-graduate staff than with auxiliary workers, all other things being equal. In another short stab at the subject, Dr. A. C. McGugan of the University Hospital in Alberta, Canada, said he wanted his patients cared for by the graduate nurse, and he wanted that graduate nurse to be a "cultural humanitarian, skilled artisan and trained scientist"—all in one skirt.

Chairman Everett Jones then started the discussion by polling the audience. Many were already using nurse's aides and attendants, considerably fewer were using trained practical nurses, a few more would take practical nurses if they were available. Only a handful were using nursing or ward clerks. Most of the following discussion came back to one point: How can you tell which child should carry which drawer? Miss Riese had the only answer: Watch all the children closely. She suggested continuous studies of individual hospital needs by committees including nurses, patients and doctors.

As it always has been, opinion was split down the middle on whether graduate nurses will or should resent the presence of practical nurses. Some observers thought that economic jealousy was bound to creep in; others saw the graduate as far removed from her practical sister as Cartier's is from Woolworth's, and with as little to fear. One or two insisted that the word nurse should be held sacrosanct, but that was not a question for hospitals or nurses to decide. The sick man calls whoever nurses him nurse, no matter where she went to school.

Surgical Conscience

In the first of the new-style discussion sessions that marked such a radical departure in program planning, the convention wrestled manfully with two of the toughest problems on a long docket of tough problems: control of surgery and specialists' contracts. The result was a tie; the 1200 administrators attending the session left these problems about where they found them—still at the head of the list and still unsolved, though unquestionably better understood.

Introducing the discussion of unnecessary surgery, Dr. Anthony Rourke of Stanford University Hospitals, San Francisco, said what is needed is a keener "surgical conscience," especially among the younger physicians. Then, in fast takes aimed at setting the main issues up for examination, Hiram Sibley of New Haven, Conn., declared that it is the board of trustees' responsibility, chiefly through control of staff appointments, to maintain surgical standards. Dr. Harvey Agnew said yes, but the board's authority has to be exercised through the medical staff, because these are medical problems. Guy Clark described an interhospital standardization program that has been working successfully in Cleveland hospitals for several years, and Dr. L. V. Ragsdale of Grand Rapids, Mich., his finger squarely on the pulse of truth, suggested that surgical judgment may be considered a matter of moral character as well as professional skill.

In the discussion that followed, several of the speakers stressed the distinction that should be made between unnecessary surgery that results from the intellectual dishonesty of the fee-seeking surgeon, and that which results from the diagnostic fallibility of the honest surgeon. The first type is comparatively rare, it was generally agreed, but these evildoers must be sought out and banished from hospital staffs. The second type needs help, not discipline.

Summing up at the conclusion of the discussion, Dr. Edwin L. Harmon of Grasslands Hospital, Valhalla, N. Y., said the answer to better surgery must be sought through education rather than legislation. Moderator Buerki tartly added that surgical appointments must be made on the basis of professional rather than social qualifications. The Chief who is selected primarily for his congeniality at poker or skill at golf is not likely to bring great credit to his hospital, Dr. Buerki observed.

Whose Money?

Ultimately, the problem of specialists' contracts boils down to the question, "Who gets the money—or profit, if any?" Keynoter John Hayes declared realistically, opening the season on radiologists. Presenting the patient's view, Stanley Howe of New Jersey said that if the specialists' passion for separate bills were to be indulged, "bills would come fluttering down like autumn leaves for services the patient didn't ask for, in amounts he isn't prepared to pay." Dr. J. A. Katzive of San Francisco pleaded the specialists' cause, making it clear that he was acting in the capacity of public defender.

Speaking for hospitals, Dr. Arthur C. Bachmeyer upheld present charges on two counts: (1) The hospital must have some revenue-producing departments to make up the losses on the dietary, engineering, housekeeping and various other general services, and (2) today's charges are in line with fees collected by specialists in private practice. This system doesn't exploit anybody, Dr. Bachmeyer asserted.

Out of the recent past and from a distance, the Attorney General of California demurred, insisting that voluntary hospitals employing physicians on salary are illegally practicing medicine. Discussants kept bumping into this opinion, some thinking it should be contested in court, others recommending the sleeping dog treatment.

As the discussion backed and filled around the problem, with administrators from all over describing their contracts (including one under which the radiologist makes $10,000 a year and works a two-hour week), it became clear that hospitals want more aggressive leadership, and more guidance, on this important issue. Speaking from the grandstand on the stage, where the delegates were perched like spectators at a swimming meet, W. E. Arnold of Jacksonville, Fla., expressed the thought that was in everybody's mind: "Let's take the offensive for a change," he said. "It's the hospitals that are exploited!"

Glen W. Fausey, Lansing, Mich.; Ronald D. Yaw, Grand Rapids, Mich., and Albert J. O'Brien, Bronxville, N. Y.

Hospitalized Personalities

Unemotional efficiency is needed in the operating room but may be lethal at the bedside, Dr. Carl W. Walter of Harvard Medical School, declared in a talk on research as an aid to better hospital care. Dr. Walter talked at the first general session of the convention Monday afternoon, after 1200 administrators had listened to Frank C. Rand, St. Louis industrialist, trace the history of industrial health, tell a corny anecdote about a woman who got kicked in the fracas, and warn that "federal money is not free money" and federal aid to hospitals should be discontinued wherever possible.

In an hour-long lecture that left his hearers exhausted but persuaded, Dr. Walter described four goals of research in administrative medicine: (1) to increase the number of efficacious hours of patient care, (2) to increase the safety of the patient, (3) to inspire a feeling of confidence and security in the patient, and (4) to decrease the cost of hospital care.

Dr. Walter's strictures on the need for cold efficiency in the operating room and warm understanding at the bedside were related to research in functional organization of hospital workers. In addition to better organization, other areas offering promise of resultful research, according to Dr. Walter, are: relieving worker fatigue, job analysis and simplification, and use of new methods, equipment and technics.

Illustrating this last point, Dr. Walter explained how nurses' time could be saved by redesigning floor kitchens on the basis of functional traffic studies. He showed how the use of new detergent materials could cut down scrubbing time.

O.P.S.

Service benefits are like brotherly love: Everybody believes in it but nobody practices it. An hour's discussion of the subject left the convention on the same old spot, reaffirming the principle and winking at the exceptions. Blue Cross Commission Chairman J. Douglas Colman gave the score: 21 plans with service benefits; 22 plans with one service limit, or hedge; 23 plans with two hedges, and 23 with three or more. This, Mr. Colman said delicately, was not counting the "unauthorized indemnity limits introduced by overenthusiastic hospital business offices."

While other speakers looked at the problem this way and that way, seeing all sides but finding no answer, one man used plain words: "Extension of the indemnity idea will mean ruination of the Blue Cross movement," said Dr. Paul R. Hawley. Raise rates if you have to, Dr. Hawley advised, but don't sacrifice that principle! The public is on to the difference, he said, and knows that the indemnity contract doesn't afford real protection as hospital prices rise. The answer to one of the arguments against full service benefits—that they encourage malingering — was given by Rufus Rorem: Control must be moral rather than professional or fiscal, he declared.

The discussants were persuaded—in principle, that is. In actual practice they found justification for what somebody neatly called "slight compromise." The reason for this, E. D. Millican of Montreal explained, was always "O.P.S." ——our peculiar situation.

Reduce Speed

Equivocation was the principal result when the convention took up the question, "Are we in danger of building too many hospital beds?" Jacque Norman of Greenville, S. C., who fired the opening round, enumerated the complications that enter into the answer: location of facili-

ties. readiness to serve, availability of staff, medical progress, type of community.

One after another, other speakers lined up on the fence. Sister Mary Reginald was pretty sure that increasing public understanding and use of hospital facilities eliminated the danger of overbuilding. Dr. A. F. Branton of Tennessee introduced a note of caution, but thought moderate bed-building was probably safe. Ronald Yaw of Grand Rapids, Mich., saw the danger stark and clear, but only in obstetrics. He advised hospitals to consult state planning and health agencies before going ahead with building projects.

John N. Hatfield, whose introduction as "the country's oldest hospital's administrator" startled everybody who wasn't paying the strictest attention, said expansion of outpatient departments, for both pay and nonpay patients, would reduce the need for beds. Mr. Hatfield said fewer than half the nation's hospitals have outpatient departments and few of the departments offer full service.

In the discussion, Msgr. Thomas J. O'Dwyer reminded the speakers that state surveys have revealed a large percentage of existing beds in substandard buildings—a factor that must certainly be considered in connection with judging overbuilding. Replying to a question, Dr. Paul R. Hawley hoped that the "earnest, but misguided and influential people who support compulsory health insurance" were beginning to modify their views, looking toward subsidies for care of the indigent only. Any kind of federal aid, it was pointed out, would increase the need for beds. But hospital beds are closed today for lack of personnel to render care, replied Dr. Nathaniel Faxon of Boston. Collecting full cost for care of indigent patients would at least give hospitals a grip on their own bootstraps, he thought.

Rufus Rorem of Philadelphia had a formula for the individual hospital to apply before deciding to build, including this list of questions: Are there unmet public needs? What do other institutions in the area plan to do? Will we have the money to run the facilities if we build them? Would expansion of the outpatient facilities eliminate the need for building? How about replacement or modernization of existing facilities? He urged a new yardstick of service: not occupancy but utilization.

Plainly, the answer to the question was: yes and no.

New Port?

Within a few minutes after it was announced to the convention, the Mellon trust's $13 million gift to the University of Pittsburgh was described as "one of the last such beneficences that we can expect." The man who called it that knew what he was talking about: He was Lewis L. Strauss of New York, financier and philanthropist who is now a member of the Atomic Energy Commission.

Tax rates are likely to stay up and interest rates down, Mr. Strauss said in an afternoon talk on financing hospital care. With endowments drying up, philanthropy dying, and costs soaring, hospitals are plainly and tragically in the middle of a fiscal muddle. Mr. Strauss characterized the present methods of financing hospitals as "dreary, hand-to-mouth and insecure—not really a system at all."

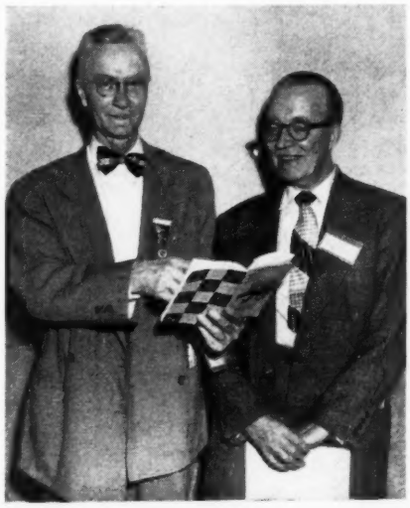
Up to this point, the speaker was clear and convincing, but scarcely original. Unlike most friends and critics of hospitals, however, Mr. Strauss had a remedy to propose: recognition of the community hospital as a local public responsibility, like the public school and the fire department, to be supported out of local general tax funds. Such a plan, Mr. Strauss insisted, would provide the benefits of public support in adequate amounts without the evils that would inevitably accompany federal subsidy, which he opposed. The American people, he said, would accept local tax responsibility for their hospitals as a reasonable solution—and it may well prove to be a necessary solution.

The printed program called for discussion following Mr. Strauss' address, but there wasn't any. Whether the silence indicated acceptance of his proposals or merely politeness to a visitor was not indicated, but it seemed likely that the storm would have to increase in fury before many hospitals would seek shelter in that particular port.

What Costs?

Ward rates have got to go up to cost, but who wants to jump first? As Chairman Albert Snoke put it, that was the problem in his community. "We're getting up there, but the public would think it was a gouge if we went all the way," he explained. As it turned out, that was everybody's problem. No one wanted to defend a rate that was below cost, but no one had a rate that equaled cost.

Reasons for upping rates popped out all over. It's the only way to justify fairer indigent rates from government



Joseph G. Norby, new president, with Hans Hansen of Grant Hospital, Chicago.

Dr. Charles Dolezal of the A.H.A. and Dr. Robin C. Buerki of Philadelphia.

Left: The Rev. E. G. Goff, Charles S. Woods, Robert Nettleton and Dr. Wilmar M. Allen. Right: Major Jack Love, Lieutenant-Colonel John Richard and Ritz E. Heerman of Los Angeles.

agencies. Compensation carriers won't pay more than published rates, which means that a rate below cost is a subsidy to industry and industry's insurers. Low rates aggravate the Blue Cross payment problem. Doctors will still give free care to ward patients who pay cost. Deficit financing must go. With published rates at cost, the voluntary hospital can still control charity on the basis of individual need.

Obviously, ward rates had to go up to cost. As soon as somebody finds out what ward costs are, that is.

Pageantry Rampant

From opening, formal, to scrolls, congratulatory, pageantry was rampant. The ceremony launching the exhibits, for example, was described as "colorful pageantry" in the convention bulletin and probably lived up to its billing. Under dimmed lights, a color guard from the Navy hospital ship *Consolation* marched the length of the convention hall and up a flight of stairs, while the photographers scampered along in front popping their flashbulbs.

Then Graham Davis gave one of his Momentous Occasion speeches, referring to those eight hospital administrators who met in a hotel room in Cleveland in 1899 to organize the association, but never had a busier week than the one they spent in Atlantic City in 1948. E. Jack Barns did the honors for the Hospital Industries Association, and the show was on.

Pageantry came to life again, in technicolor, at the Honor Night ceremony, when 550 members and guests assembled at a full-dress banquet to applaud heartily while past president James A. Hamilton received the associations' award of merit, and to look on as Senator Lister Hill presented special certificates of appreciation to fifty outstanding contributors to American and Canadian hospitals, thirty-three of whom were present to receive their awards in person —an awe-inspiring concentration of millions. In addition, plaques were presented to representatives of nine foundations in recognition of their efforts on behalf of hospitals.

At Thursday night's banquet, pageantry got in its final licks when commemorative scrolls were presented by the Catholic Hospital Association, the American College of Surgeons and the American Protestant Hospital Association, among others, and when Graham Davis handed the heavy end of the pole to Joe Norby.

Officers

In addition to Mr. Hatfield (see page 3), officers elected by the American Hospital Association were: first vice president, Dr. Edwin L. Crosby, Baltimore; second vice president, Mary C. Schabinger, Wauseon, Ohio; third vice president, William P. Butler, San Jose, Calif; treasurer, Dr. Arthur C. Bachmeyer, Chicago; trustees: Msgr. John J. Healy, Little Rock, Ark.; F. Ross Porter, Durham, N. C.; Dr. Charles F. Wilinsky, Boston; delegates-at-large: Frank Walter, Portland, Ore.; Dr. Frank Bradley, St. Louis; John H. Hayes, New York, and Nellie Gorgas, Minneapolis.

Theirs Is the Kingdom

Never underestimate the power and glory of a women's auxiliary. And now they are coming into a kingdom, for at their first national conference, held in connection with the A.H.A. convention, the 400 or so delegates voted to effect an affiliation with the A.H.A.

Only the schmoe type of administrator still regards a women's auxiliary as a beloved but lucrative nuisance. War and inflation have completed the demonstration that without the initiative and vigor of these women's groups hospitals would be underequipped, undermanned and underfinanced.

Over and above the equipping, staffing and financing, anyone who attended the women's conference at Atlantic City could see that the job these groups do in building community good will for the hospital outshines all their other powers and glories.

Regional meetings of women's auxiliary groups have been a little heavy on knitting and orchids. Not so, this first national gathering, which was to the outsider, amusing and refreshing, to the delegate, earnest and stimulating.

Upstairs in the general sessions on administration the presidents and professors and chiefs of this and that were pontificating, and part of it made sense.

Downstairs the gals and grandmas were babbling and bobbing up and down about fairs and raffles and white elephant sales, and all of it made cents—plenty of cents. There was a general air of undecorum in delightful con-

Left: William Edwin Arnold and Dr. Charles L. Clay. Right: Dr. Woodward of V.A., Ralph Hueston, Dr. Albert G. Engelbach, Everett W. Jones, Charles Auslander, Harold C. Mickey and W. B. Forster.

trast to the starched, stuffed or paunched shirts of the males upstairs.

For instance, the ushers brought to the platform an amazing number of suggestions as well as questions for the speakers.

"Does anybody want to know how to make $1500 without effort?"

"Mrs. Baker would like to meet Mrs. Candby in the back of the hall."

"I'd like to talk about Rhode Island."

"Will people who are smoking stop smoking during the program."

And then: "Our next speaker is assistant to the Federal Security Administrator. Besides that, she has done all of these things"—whereupon the delightful chairman who said she was fresh from a New Jersey dairy farm held up a tightly packed page of typescript. [Applause.]

Mary Switzer, who is assistant to the Federal Security Administrator and has done all of those other typewritten things, made her first address since returning from Britain, France and Germany. In regard to the problem of democratizing Germany, she said:

"Germany lacks any citizen pressure; there is no interest in gadflying the local office holders for better government. Our military government is beginning to see that the key to developing such organized community will is through contact with the women. Women in Germany have never played a role in government, but now they are so far in the majority that if they cannot be carried along in the democratization process it will fail."

Miss Switzer sees a great need for German women in hospital auxiliaries. She so touched the heart of her audience by her description of nurses going about their hospital duties patched, stockingless and wearing bands of tape to support their feet, that the delegates immediately decided to start sending suitable shoes to the nurses in the Wiesbaden area where these conditions were observed.

To make $1500 without effort, one Pennsylvania hospital raffles off week-end tours to New York City, including accommodations at the Biltmore, tickets to "Life With Mother" and "Mr. Roberts" and $50 pocket money.

In Providence, R. I., an auxiliary sold chances on a mink coat and netted $7724.

However, most of the auxiliaries make hospital money the hard way—cook books, coffee shops, thrift shops, gift shops, garden tours, baby books, and fairs.

The far famed Morristown cook book arrived in the best seller class only following such prolonged effort on the part of the chairman that she and her family could not eat off the dining table for weeks on end; it was in use as an editorial office.

Males would not have been hardy enough to stand up under the auxiliary sessions, stretching as they did each morning from 9:15 to 12:30 and never a relaxing moment. Afternoons, the ladies could attend general convention sessions until 3:30 at which hour the A.H.A. provided them with a reception, style show, astrology talk, palm readings, tea, sherry wine, petits fours and more chances for chatter —hospital chatter.

How Good?

The final meeting on the program produced some unexpected speakers with some worth while ideas. Dr. Morris Fishbein, the scheduled speaker, was ill and unable to attend, so a panel on professional problems was presented instead, including President Graham Davis, Treasurer Arthur C. Bachmeyer, and Dr. Harold C. Lueth, dean of the University of Nebraska Medical School at Omaha and administrator of the University Hospital.

Dr. Lueth's subject was education, but sparks from his wheel flew in all directions. Standards must never be relaxed as a means of solving an immediate problem, he warned. "Unfortunately, the production line and mechanization have led the average American to think that all things that are big are good," he said. "But quality of performance is a characteristic of the professions. In the trades the emphasis is 'How much?' In the professions, it is 'How good?'"

Membership in a profession implies obligations, Dr. Lueth reminded doctors, nurses and administrators. "The responsibility of the profession does not end with supervision but involves the disciplining of members who fail to maintain adequate standards of performance," he specified.

Left: Blue Cross officials, Richard Jones and J. Douglas Colman. Right: Jessie Turnbull, new A.C.H.A. president, and the president-elect, Dr. Wilmar M. Allen.

Rendezvous at Sea

"He sharpened all the pencils so care-ful-lee, that now he is the ruler of the Queen's na-vee."

That was when Britannia ruled the wa-a-aves. Just now Columbia's the gem of the ocean, and when it comes to sharpening pencils American efficiency makes British, Germanic and Muscovite efficiency look strictly leukemic.

Take the Monday 2 p.m. tour of the *U. S. S. Consolation,* the 15,000-ton hospital ship anchored from 4 to 10 miles off the Atlantic City coast. You will see shortly why its exact position cannot be revealed.

If, as is sometimes sung, "the best things in life are free," the one best thing in Atlantic City life was this visit to the hospital ship. For economic or patriotic or professional reasons everybody wanted to tour the *Consolation.*

Naval efficiency makes such arrangements air, or maybe water, tight. We queued up in the Auditorium lobby and in due or past-due course we reached the desk where a glamourous chief petty officer filled out a complimentary ticket for the excursion. Orders were to report at 1:40 sharp at the basement level of the Auditorium where complimentary navy buses would transport the visitors to a pier where a complimentary voyage on a navy LCI (landing craft, infantry) would bring us to the *Consolation.*

At 1:40 an eager group had assembled. There were assorted hospital administrators of both genders, U.S.P.H.S. men privileged to wear the navy blue but until now unprivileged to tour a hospital ship, several army officers privileged to see this demonstration of naval efficiency, eight nuns privileged to wear a billowing habit on the billowing sea, and sundry others privileged to wear convention badges on chest or bosom.

Sardined into one small navy bus, the first contingent took off for the pier, leaving the better half standing disconsolately on the pavement. It was hardly more than a generous half hour before Buses Nos. 2 and 3 arrived. Meantime was demonstrated that board-convincing argument that the convention delegate gains most of all not from the meetings he attends but from the contacts he makes. The pace of contact making was terrific.

With a hint of bargain-counter jostling Bus No. 2 filled in a twinkling, but the seaman 1st class who was the driver hurried off to a drinking fountain or some more urgently needed facility and forgot to hurry back. During the ten minutes that Bus 2 stood filled but unmanned, a good many trippers decided to heck with it and went back to the convention hall or horoscope reader or shooting gallery, for Atlantic City is culturally so fascinating that there is consolation even for an unattained *Consolation.*

Forty minutes late, Bus No. 2 pulled out leaving Bus No. 3 stark empty. However, with sailorly comradeship the driver of No. 2 called to his shipmate:

"Better follow right after me, pal; I'm about out of gas."

With that we were off in the direction of the Coast Guard pier where the promised LCI's were to receive their eager civilian cargo. Ocean breezes soon ruffled all except hairless heads, and hopes rallied bravely.

At the pier the bus occupants scrambled out and looked about for the boats that had carried brave men up the beaches to Okinawa and Iwo Jima and Glory . Nary an LCI. Those with the mariner's farsighted gaze scanned the waters, but a gauzey haze wrapped sea craft in a shroud of silence.

Some improved the time by seeking their sea legs in powerful strides up and down the pier. Some just sat on the landward side of the wharf listening to the gentle lapping of the surf and regretting expensive lunches and lack of Mothersill's. Others pursued their convention contacts, now growing a little forced.

After fifteen minutes the word crept around that the LCI was not coming, that there would be no more trips to the *Consolation* that day.

The next trip, it was said, would start at 7:30 a.m. Tuesday. All that would be necessary would be to queue up in the Auditorium lobby where in due course a glamourous CPO would fill out a complimentary ticket for the bus ride. The bus would transport delegates to a pier where there would be a complimentary ride on a LCI.

But "complimentary" and "navy" suddenly seemed conversationally incompatible. Who was Oliver H. Perry talking to anyway when he implored: "Don't give up the ship!"? Certainly not to hospital administrators!

A. C. H. A.

To make a lot of lopsided people round, it ought to be worth $425,000.

The American College of Hospital Administrators is prepared to do this rounding-out job provided it gets this comparatively moderate sum.

The college regent will bear down upon a moneyed man or a foundation all primed with the professional counsel of a fund raising firm. In a well rehearsed story he will offer the lucky donor the chance to contribute all or part of $50,000 toward in-service training through institutes; $150,000 toward expansion of college courses and internships; $50,000 toward development of testing methods for selecting administrators, and $125,000 toward scholarships of the Rhodes or Nieman types.

Colleges sometimes forget to concentrate on education, but the A. C. H. A. has not made that mistake either in its 1948 convention or its newly announced five-year program. At Atlantic City reports had to be dug for, but educational ideas were lying around for any one to pick up.

Jessie J. Turnbull is to take over the college presidency following Edgar C. Hayhow. Dr. Wilmar M. Allen, of Hartford, Conn., is president-elect; E. I. Erickson, Chicago, first vice-president, and Sr. Loretto Bernard, New York City, second vice president.

Regents elected this year are: Region 1, Dr. Wilmar Allen; 4, Edgar C. Hayhow; 7, Dr. Merrill F. Steele; 10, Victor Anderson, and 13, Dr. Anthony J. J. Rourke.

A.C.H.A. fellows march into the convocation hall on Sunday afternoon.

At the convocation 19 fellows were accepted in membership; 63 received certificates of membership, and 147 were accepted as nominees.

Honorary fellowships were conferred on Annie Goodrich, Mrs. Albert G. Hahn and Dr. Harley A. Haynes. As a 50th anniversary tribute, President Graham L. Davis, of the American Hospital Association, was presented with a commemorative plaque by the college.

Later George Bugbee, executive secretary of the A. H. A., received the award presented annually by the college.

Dean Emeritus Christian Gauss of Princeton University, the banquet speaker, had two strikes on him at the start—poor food and service and an introduction to a waning and sleepy audience shortly before the stroke of 10 p.m. Both he and the convocation speaker, Dr. Harry Milton Taylor, put the emphasis on respect for the human personality.

Speaking honors were easily awarded to Marshall E. Dimock, Chicago professor, whose first guiding principle in education for hospital administration is to take lopsided people and make them round, as indicated in the opening sentence.

Dr. Dimock thinks hospital administrators should be developed into broader, more unified, more integrated persons: (1) who will give their employes motivation and incentive so that they may take pride in craftsmanship; (2) who will give concentrated thought to institutional living by introducing correctives that will convert situations the public does not like into situations it approves, and (3) who will continue in study and self-growth through refresher courses and other means.

"We must stop the type of education that produces specialists," Dr. Dimock declared. "The good administrator is not a technical specialist but is a master of human relations.

"If we are to bridge the gap between the specialist and the generalist, we must expect to intensify our educational pro-

Below, left: Mrs. Albert Hahn receives honorary fellowship in the College of Hospital Administrators from President Hayhow. Right: Honorary fellowship is also bestowed on Annie Goodrich.

gress. This, I believe, the A. C. H. A. is now doing."

President Curtis McGraw of the McGraw-Hill Publishing

A.P.H.A. Presidents: Elliott (past); Marshall (present) and Benson (future).

Company, also president of the board of Princeton Hospital, told the administrators not to be so depressed by the current economic problem of inflation as not to recognize that a great new potential clientele is available for the private hospital. The farmers and certain groups of industrial workers are much better able to pay their hospital bills than they used to be; therefore, the administrator should look in both directions.

Mr. McGraw sees opinion polls as offering the weak administrator a safe way to say, "Me, too." These polls offer great pitfalls if used as a guide to policies. The hospital administrator must not take the opinions of the ignorant as a guide but must stoutly assert his own ideas of the best type of democracy. He must not be persuaded by what everybody else believes, but must decide what he thinks is right and then persuade people to agree with that policy.

Protestants

Meeting in their twenty-seventh annual convention Friday and Saturday preceding the main event, members of the American Protestant Hospital Association came to grips with a question that is close to the roots of what ails hospitals: Can medical science and the Christian principles of faith, hope and love thrive in the same institutional atmosphere?

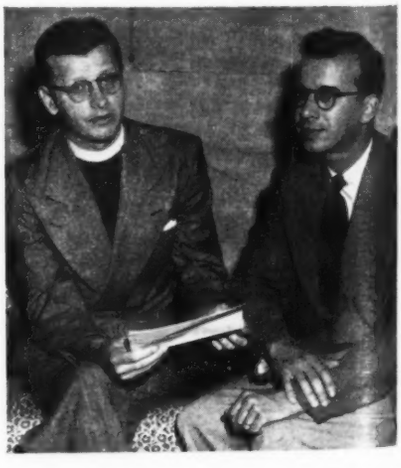
In a panel discussion, "Why is the Church in the Hospital Business?" the issue was plainly stated by Rev. Granger E. Westberg, chaplain at Chicago's Augustana Hospital. The answer emerged clearly in the ensuing discussion: Science and Faith must work side by side in the great cause of healing. A hospital that fails to administer to the spiritual as well as the physical needs of the patient is no real Church hospital, declared Rev. Malcolm Ballinger, chaplain of the University of Michigan Hospital at Ann Arbor, reading a paper prepared by Rev. Russell L. Dicks, professor of pastoral care at Duke University.

Lois Hahn registers Creighton Mann of Evansville at the A.P.H.A. session.

What of spiritual care in the non-Church hospital? An atmosphere of friendly, kindly service will prevail in every institution whose administrator believes and lives the Golden Rule, discussants agreed. This is the essence of Christian spirit, it was acknowledged, but many felt that the Church hospital had an additional obligation to offer the services of a trained spiritual leader — the hospital chaplain. Specific clinical training in the spiritual needs of the sick is essential for the successful chaplain, speakers warned. A well trained chaplain is a great aid to physicians whose patients require psychotherapy in addition to surgery and medications, it was added. Dr. Joseph C. Doane of Philadelphia, urged hospitals to banish "spiritual paupers" with no understanding of these needs of visitors as well as patients.

Dr. L. B. Benson, administrator of the Bethesda Hospital, St. Paul, Minn., was named president-elect of the Protestant association as Dr. Chester C. Marshall of Brooklyn's Methodist Hospital took over the presidency from Rev. Paul C. Elliott of Los Angeles. Other officers elected were: first vice president, Leo M. Lyons, St. Luke's Hospital, Chicago; second vice president, J. G. Dudley, Memorial Hospital, Houston, Tex.; treasurer, Ritz E. Heerman, the California Hospital, Los Angeles; trustees, C. E. Copeland, St. Louis; Rev. Joseph A. George, Chicago; Bryce L. Twitty, Tulsa, and Paul C. Elliott.

In other addresses included in the program, Dr. Malcolm T. MacEachern (see cover) explained in detail the point-rating system now used to judge hospital performance for the College of Surgeons, Dr. Paul R. Hawley declared that only a unified Blue Cross-Blue Shield program supported alike by hospitals and doctors everywhere can save the voluntary medical care system in America, and Everett W. Jones, vice president of The Modern Hospital Puplishing Company, described the successful public relations programs by means of which hospitals in



Rev. Granger Westberg of the chaplains' section and Rev. L. R. Potter.

Cincinnati, Minneapolis, Wheeling, W. Va., and elsewhere have explained hospital costs to their communities.

ACCOUNTING SHORT CUTS

Pay Roll Procedures

ROBERT PENN
Accounting Consultant, Chicago

IN THE first article in this series on pay roll procedures, three of the nine forms needed to facilitate the work of the pay roll clerk were described. These included the employment application, employe's record, and time and salary computation card. In this discussion, we will consider the employe's earnings record, pay roll check for peg board, and pay roll summary.

EMPLOYE'S EARNINGS RECORD

The employe's earnings record is prepared by the pay roll clerk upon receipt of the employment application. If the employe is not on a part-time or hourly basis, the pay roll clerk should record in pencil on the upper part of the form the regular earnings and deductions for a complete pay roll period, whether it is weekly, biweekly, semimonthly or monthly. The earnings record should be filed alphabetically in the department section, either in a binder or in a tray.

The earnings record is prepared at the same time that the pay roll check is typewritten by means of a carbonized area on the back of the pay roll check. It will be noted that there are holes punched on the upper left hand and right hand sides of the check so that the entry on the employe's earnings record can be made on the proper line. It is important that the same line number be used for all employes paid on the same basis; for example, if line 3 is being used for the pay roll period from February 1 to 15, inclusive, and an employe began work on February 10, the checks for that period should be typed on line 3. If the employe is being paid on a weekly basis, the same lines should be used for that period.

The form is designed to furnish complete information regarding payment made and the number of hours or days worked. Thus during the period from April 1 to 15 (as shown on the form illustrated), the employe was absent three days on account of illness. Furthermore, during the pay roll period ended July 15, the employe was absent six days on account of vacation.

Provision is also made for recording the check number of the pay roll check in the event it is necessary to refer to it.

Instead of waiting until the end of the year to total the earnings of the employe and the withholding tax, we suggest that this be done quarterly. Inasmuch as the earnings record is a complete record of earnings, deductions and so forth, the totals of the various columns can be readily proved. The totals should be recorded in a color other than black to facilitate adding the quarterly totals at the end of the year. Footing the columns quarterly will eliminate to a large extent the peak load, as far as this phase of the work is concerned, at the end of the year.

When an employe leaves or is discharged, the date of leaving should be recorded on the earnings record form. After the issuance of the last pay roll check due the employe, the earnings record should be filed back of a guide headed, "Employes Discharged — in Process."

Not later than thirty days after the date of leaving, a withholding receipt should be prepared in quadruplicate. The original and duplicate should be mailed to the employe, and the triplicate and quadruplicate should be filed back of a guide headed, "Withholding Receipts Issued." A notation should be made on the earnings record that withholding receipt has been issued and the records should be filed alphabetically back of a guide headed, "Employes Discharged."

PAY ROLL CHECK FOR PEG BOARD

Upon completion of the pay roll computation on the time and salary computation card, the time cards should be sorted alphabetically by departments. The pay roll clerk is now ready to type the pay roll checks and earnings records simultaneously.

The pay roll check has seven features:

1. The check consists of two parts —the lower portion is the check and the upper part shows the earnings, deductions and net amount due the employe. The upper part may be retained by the employe.
2. The upper portion is carbonized on the reverse side so that it will record simultaneously the same information on the employe's earnings record.
3. There are two holes in the upper portion of the check—on the left side and on the right side—in order to align the check on the appropriate line of the employe's earnings record.
4. A duplicate of the check is obtained by means of a one-time carbon sheet inserted between the check and the duplicate copy.
5. The duplicate copy of the check has holes punched on the left hand side so that it can be placed on a peg board to obtain department totals and also prove the accuracy of the checks issued.
6. The snap-out feature of the check is a time saver.
7. The check may be either typewritten or written in long hand. How-

Name	Jones			Jean			Soc. Sec. No.				Dept.			Employee No.		
EXEMPTIONS CLAIMED	DATE	DATE	DATE	77.50	2.50	80.00	9.90						9.90	6760		
Self	1			EARNINGS			DEDUCTIONS						TOTAL	NET AMOUNT OF CHECK	CHECK NO.	
Dependents	—			CASH SALARY	Other Compensation	TOTAL EARNINGS	Withholding Tax									
TOTAL	1															
	PAYROLL PERIOD ENDED															
1	1-15	12D		75.00	2.50	77.50	9.20						9.20	65.80	5	1
2	1-15	14D		75.00	2.50	77.50	9.20						9.20	65.80	63	2
3	2-15	13D		75.00	2.50	77.50	9.20						9.20	65.80	126	3
4	2-29	11D		75.00	2.50	77.50	9.20						9.20	65.80	182	4
5	3-15	12D		75.00	2.50	77.50	9.20						9.20	65.80	239	5
6	3-31	13D		75.00	2.50	77.50	9.20						9.20	65.80	302	6
7				450.00	15.00	465.00	55.20						55.20	396.80		7
8																8
9	4-15	10D 3I		75.00	2.50	77.50	9.20						9.20	65.80	369	9
10	4-30	13D		75.00	2.50	77.50	9.20						9.20	65.80	421	10
11	5-15	13D		75.00	2.50	77.50	9.20						9.20	65.80	485	11
12	5-31	14D		75.00	2.50	77.50	9.20						9.20	65.80	561	12
13	6-15	12D		75.00	2.50	77.50	9.20						9.20	65.80	624	13
14	6-30	13D		75.00	2.50	77.50	9.20						9.20	65.80	687	14
Q				450.00	15.00	465.00	55.20						55.20	396.80		Q
1	7-15	7D 8V		77.50	2.50	80.00	9.90						9.90	67.60	742	1
2	7-31	14D		77.50	2.50	80.00	9.90						9.90	67.60	803	2
3	8-15	13D		77.50	2.50	80.00	9.90						9.90	67.60	865	3
4	8-31	13D		77.50	2.50	80.00	9.90						9.90	67.60	921	4
5	9-15	12D		77.50	2.50	80.00	9.90						9.90	67.60	992	5
6	9-30	13D		77.50	2.50	80.00	9.90						9.90	67.60	1051	6
7				465.00	15.00	480.00	59.40						59.40	408.60		7
8																8
9	10-15	12D		77.50	2.50	80.00	9.90						9.90	67.60	1120	9
10	10-31	14D		77.50	2.50	80.00	9.90						9.90	67.60	1182	10
11	11-15	12D		77.50	2.50	80.00	9.90						9.90	67.60	1243	11
12	11-30	13D		77.50	2.50	80.00	9.90						9.90	67.60	1305	12
13	12-15	12D		77.50	2.50	80.00	9.90						9.90	67.60	1372	13
14	12-31	12D		77.50	2.50	80.00	9.90						9.90	67.60	1437	14
Q				465.00	15.00	480.00	59.40						59.40	408.60		Q
Total				1830.00	60.00	1890.00	229.20						229.20	1600.80		Total

Name of Husband		Date Employment Started	1-1-47
Address	5861 Main Avenue	Reason for Leaving	Family moved to California
Phone	Mid. 5674		

EMPLOYE'S EARNINGS RECORD

1. RECEIPT OF EMPLOYMENT APPLICATION.

(a) Upon receipt of Employment Application an Employe's Earnings Record should be prepared. Note: If employe is not on part-time or hourly basis then record in pencil in upper part of form the regular earnings and deductions for a complete pay roll period, whether it be weekly, biweekly, semimonthly or monthly.

(b) The Earnings Record should be filed alphabetically in the department section.

Note: If it is the practice of the hospital to give each employe a number, then the Earnings Record should be filed in employe number order in the department section.

2. TYPING OF PAY ROLL CHECK:

(a) This record is prepared at the same time that the pay roll check is typewritten by means of a carbonized area on the back of the pay roll check.

(b) It will be noted that there are holes punched on the upper left hand and right hand sides of the check so that the entry on the Employe's Earnings Record can be made on the proper line. We suggest that the same line number be used for all employes paid on the same basis; for example, if line 3 is being used for the pay roll period from February 1 to February 15, inclusive, and an employe began work on February 10, the check for that period should be typed on line 3.

In the case of employes being paid on a weekly basis, the same lines should be used for that group.

3. AT THE END OF EACH QUARTER:

(a) At the end of each quarter the columns should be footed and the totals proved. Record totals in color other than black to distinguish them from detail amounts.

4. AT THE END OF THE YEAR:

(a) Add the totals for each quarter and prove totals for the year.

5. UPON RECEIPT OF NOTICE OF DISCHARGE OR RESIGNATION OF EMPLOYE:

(a) When an employe leaves or is discharged the date of leaving should be recorded on the Employe's Earnings Record.

(b) After the issuance of last pay roll check due employe the Employe's Earnings Record should be filed back of a guide headed "Employes Discharged—In Process."

(c) When convenient, but not later than thirty days after date of leaving, withholding receipts should be prepared in quadruplicate; the original and duplicate should be mailed to the employe and the triplicate and quadruplicate filed back of a guide headed "Withholding Receipts Issued."

(d) The Employe's Earnings Record should be checked to indicate that a withholding receipt has been issued and filed alphabetically back of a guide headed "Employes Discharged."

ever, we strongly recommend that it be typewritten since this makes a more legible employe's earnings record.

The "Pay Roll Period Ended" section may be used for recording in code the productive and nonproductive time of full-time employes and also the time of part-time employes. This information is necessary for preparing the personnel statistics form.

The following code is being used in some hospitals:

D—Days Worked
EH—Hospitalization
I—Illness
H—Hours Worked
T—Part-Time Employe
V—Vacation

The code should be designed to fit the particular needs of a hospital.

Upon completion of the checks for a department, the duplicate copies of checks should be placed on the peg board so that the top section beginning with "Pay Roll Period Ended" is visible. Thus, the duplicate checks so arranged become in effect a listing of the pay roll checks.

Each column should be footed and the totals should be recorded on the pay roll summary in the appropriate column. The amounts recorded should be verified as to arithmetical accuracy.

The peg board can accommodate approximately thirty duplicate checks and if there are more than thirty employes in a department, it is necessary to repeat the procedure described.

Another advantage of this type of check is that when reconciling the bank account at the end of the month, it is not necessary to check the canceled checks to the duplicate copies. Instead, the canceled checks should be sorted numerically, the missing numbers listed and the amounts applicable to the missing numbers obtained from the duplicate copies of the checks. This procedure will save a considerable amount of time in reconciling the bank account.

To speed up typing the upper portion of the check, we suggest that the tabulating feature of the typewriter be used when typing the checks.

The duplicate copies of the checks should be filed in numerical sequence and thus become in effect a master file of all pay roll checks issued. It will be noted that the words "Not Negotiable" are printed on the duplicate to prevent its being used as a check.

In order to speed up the cashing of the pay roll checks, it is recommended

PAY ROLL CHECK FOR PEG BOARD

1. COMPLETION OF TIME CARDS:

(a) Upon completion of pay roll computations on Time and Salary Computation Cards the cards should be sorted alphabetically by departments.

Note: Employe's Earnings Records are filed alphabetically by departments.

2. TYPING CHECKS:

(a) Type check after placing Employe's Earnings Record on proper line (refer to item 2 of Employe's Earnings Record).

(b) Use the "Pay Roll Period Ended" section for recording in code the productive and nonproductive time of full-time employes and time of part-time employes. This information is necessary for preparing the Personnel Statistics form.

Following code is suggested:

D—Days worked
EH—Hospitalization
I—Illness
P—Part-time employe
V—Vacation
H—Hours worked

3. COMPLETION OF CHECKS FOR DEPARTMENT:

(a) Upon completion of checks for a department the duplicate copies of checks should be placed on Peg Board so that the top section beginning with "Pay Roll Period Ended" is visible.

(b) Each column should be footed and the totals recorded on Pay Roll Summary in the appropriate columns.

(c) The amounts recorded should be verified as to arithmetical accuracy thus:

(1) The sum of the "Cash" and "Other" columns should equal the amount shown in "Total" column.

(2) The sum of "Withholding Tax" and other deductions shou'd equal the amount shown in the "Total" column.

(3) The amount shown in the "Net Amount of Check Column" should be the difference between the "Cash" and "Total Deductions" amounts.

If the amounts agree, it can then be assumed that the checks prepared are arithmetically correct and the pay roll checks are ready for distribution to employes.

4. MORE THAN 30 EMPLOYES IN DEPARTMENT:

The Peg Board can accommodate about thirty duplicate checks, and if there are more than thirty employes in a department, then procedure 3 should be followed two or more times, if necessary, in order to determine the total amount of earnings, and so forth for each department.

PAY ROLL SUMMARY

1. A Pay Roll Summary sheet should be used for each pay roll period.

2. The totals of the various columns should be recorded in the appropriate columns of the Pay Roll Summary sheet, namely, "Cash Salary," "Other Compensation," "Total Earnings," and so on.

3. The columns should then be footed and verified in the same manner that the totals for each department were verified (see instruction 3(c) of Pay Roll Check for Peg Board).

4. A Voucher Check should be prepared for the total amount shown in the "Net Cash Paid" column. In the lower portion of the voucher check, type merely the pay roll period covered by the check. The distribution in the Voucher Register should be obtained from the Pay Roll Summary sheet.

1-15 13D	75.00	2.50	77.50	9.20					65.80	1666
PAYROLL PERIOD ENDED	EARNINGS: Cash	Other	Total	DEDUCTIONS: With. Tax	Blue Cross			TOTAL	NET AMOUNT OF CHECK	CHECK No.

St. Joseph's Hospital, New Hampton, Iowa — Employee Detach and Retain This Statement BEFORE Depositing Check

PAYROLL CHECK

ST. JOSEPH'S HOSPITAL
New Hampton, Iowa

VOID AFTER 30 DAYS

Date Jan 17 1947

No 1666

PAY TO THE ORDER OF Jean Jones $65.80

The sum of $65 and 80cts DOLLARS

ST. JOSEPH'S HOSPITAL

FIRST NATIONAL BANK
New Hampton, Iowa

VOID

Administrator

PEG BOARD, at right, can accommodate about thirty duplicate checks. The procedure is described in the adjoining column.

PAY ROLL SUMMARY

PERIOD FROM January 1 TO January 15 1947 INCLUSIVE

	DEPARTMENT	Check Numbers	EARNINGS: Cash Salary	Other Compensation	Total Earnings	DEDUCTIONS: Withholding Tax					Total Deductions	Net Cash Paid	
1	Administration	1- 9	970	40	410	40					40	370	1
2	Dietary	6-14	480	100	580	80					80	500	2
3	Laundry	15-18	180	80	260	80					40	220	3
4	Housekeeping	19-26	910	70	980	10					30	950	4
5	Heat, Light, Power and Water	27-28	980	10	990	90					90	900	5
6	Maintenance and Repairs	29	170		170	10					10	160	6
7	Motor Service												7
8	Medical and Surgical Service												8
9	Nursing Service	30-60	4 980	930	5 910	880					880	5 030	9
10	Nursing Education												10
11	Medical Records and Library	56	100	10	110	10					10	90	11
12	X-Ray	57-58	980	80	970	80					80	890	12
13	Laboratory	59	180	80	260	20					40	220	13
14	Operating Rooms	60	190	10	160	20					40	120	14
15	Delivery Rooms	61	100	10	110	10					20	90	15
16	Nursery	62	100	10	110	10					10	90	16
17	Pharmacy	63	170	10	180	20					40	140	17
18	Physical Therapy												18
19	Emergency Service												19
20													20
21													21
22													22
23													23
24													24
25													25
26	Totals		4 900	640	5 540	440					940	4 600	26

CHECKED BY — APPROVED BY

that the words, "Void After Thirty Days" be printed on the face of the check. Although it may not be valid, it still has the effect of acting as a spur to the employe to cash the check within thirty days.

It is advisable to separate the pay roll account from the general checking account. It is then easier to reconcile both the pay roll account and the general checking account at the end of each month.

Pay Roll Check Envelope. This inexpensive envelope is designed so that the name of the employe only is exposed. If, as sometimes happens, all the checks cannot be distributed to employes during the day, the checks can be placed in this type of envelope, sealed and given to the cashier for distribution.

If the employe has resigned or has been discharged, the address can be recorded on the envelope and it can be mailed.

Peg Board. The peg board is made of plastic and the pegs are so arranged that the two pegs hold each check in place. The board is designed so that it will not mar the desk in any way. It is also inclined at an angle to facilitate adding the duplicate checks.

PAY ROLL SUMMARY

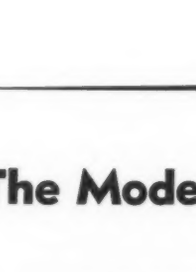
The pay roll summary provides columns for the departments, earnings, deductions and net amount of checks. As stated previously in describing the pay roll check, the totals for each department are recorded in the appropriate columns of the pay roll summary sheet. The columns are footed and verified in the same manner that the totals for each department are verified.

A pay roll summary sheet should be used for each pay roll period whether it is weekly, bi-weekly, semimonthly or monthly.

A voucher check should be prepared for the total amount shown in the "Net Cash Paid" column. It is not necessary to type in the lower portion of the voucher check the analysis of the pay roll. This analysis for distribution in the voucher register should be obtained from the pay roll summary sheet.

The printed department accounts conform with those recommended by the American Hospital Association and there are six blank lines to take care of additional departments.

The Modern Hospital Gold Medal Award



Emanuel Hayt

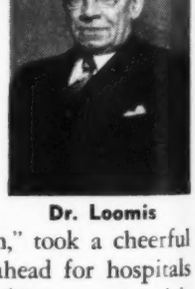
Emanuel Hayt of New York is the winner of The MODERN HOSPITAL Gold Medal Award for the best original article published during the 1947-48 magazine year. The prize-winning article, entitled "Legal Aspects of Specialists' Contracts," was published in The MODERN HOSPITAL for May 1948.

Dr. Frederic M. Loomis of Oakland, Calif., was awarded the Silver Medal and Honorable Mention for his article, "Hospitals Are Like People," which appeared in October 1947.

The awards are made each year on the basis of the original contributions which offer the most valuable assistance to the field of hospital administration. Standards of judging value include the improvement in hospital service or economy that the contribution promises, practicality, breadth of interest and application and clarity of presentation. The committee making the awards is headed by Dr. Arthur C. Bachmeyer of the University of Chicago. Other members include Dr. Robin C. Buerki of Philadelphia, Dr. Basil C. MacLean of Rochester, N.Y., and William J. Donnelley of Greenwich, Conn.

Mr. Hayt is a nationally recognized authority on legal problems and procedures affecting hospitals. Many of his books and articles on hospital law have been written in collaboration with his wife and law partner, Lillian R. Hayt. Mr. Hayt is a lecturer in the graduate course in hospital administration at Columbia University and has appeared many times as a speaker at national and regional hospital meetings.

The prize-winning article was a study of the legal problems hospitals become involved in when making contracts with radiologists and other physician specialists. Especially, Mr. Hayt examined these contracts from the standpoint of their effect on the tax-exempt status of the hospital. The article included a study of court decisions involving the so-called "corporate practice of medicine" by hospitals. "If it were illegal for a nonprofit hospital corporation to employ physicians," Mr. Hayt concluded, "it would be equally unlawful to employ nurses, pharmacists and all other state-licensed professional personnel."



Dr. Loomis

In his article on human relations in hospitals, Dr. Loomis, who is author of many popular books and magazine articles about medicine, including the best-seller, "Consultation Room," took a cheerful view of what lies ahead for hospitals and medicine. Describing a recent visit to his medical school, he said, "I found extraordinary emphasis being placed on the importance of the emotions which lie hidden behind the curtain of too obvious symptoms." The hospital administrator, Dr. Loomis declared, has become "the liaison officer between medicine and business."

EMPLOYMENT TESTS

while adding to efficiency can save a hospital money

D. H. RADLER
Hospital Personnel Consultant
Chicago

FOR many years employment tests have been used in industry with great success. They have decreased costs in many ways—by decreasing turnover, by promoting efficiency, by employing people who have fewer and less costly accidents and make less wasteful mistakes. In spite of this, tests are seldom used in hiring hospital employes even though hospitals are faced with tighter budgets and more necessity for economy than are industrial firms.

Tests are, first of all, the laboratory measure of applicants for employment. Hospital administrators would not tolerate neglect of laboratory guidance in medical diagnosis on the part of one of their staff. Is it unseemly to ask that they maintain an equally scientific attitude toward the selection of their employes? Yet hospital personnel is hired by old, inefficient, pseudo-scientific procedures—in the midst of the most impressive massing of scientific endeavors in other fields!

GAINS CAN BE MADE

The reason for this apparent paradox is twofold. First, there is the fact that tests are considered an expensive device, and, second, the whole subject of psychological testing is mistakenly considered to be too complex for the installation of a testing program in hospitals to be feasible.

It is our intent to dispel both of these unfortunate illusions by explaining the rationale underlying psychological testing in employment and by advancing concrete suggestions for the installation of a testing program which will pay for itself many times over in increased efficiency and decreased cost.

The applicant carries with him into the testing situation all that pertains to his potential value as an employe. The job of the test is to bring him into standardized situations in which his behavior will serve as a reliable basis for determining his potential value to the hospital.

The advantages of using tests are numerous. First, there is the fact that the applicant cannot and does not present a complete and unbiased history. Tests can reveal capabilities and inabilities of which the applicant is unaware or chooses to conceal. Second, test results give information that is easy to record in full. Third, tests which are standardized permit greater objectivity in appraising applicants—even the most experienced personnel interviewer is controlled to a certain extent by subjective, unsound judgments. Fourth, systematic scoring precludes subjectivity in organization of selection results. And fifth, tests allow for systematized comparison between applicants, which is highly inefficient when based on interview alone.

Tests are divided into two types—those that measure innate abilities, or *capacity* tests, and those whose results depend to a great extent on experience or training, called *proficiency* tests. In hiring laboratory technicians and similar highly skilled workers the proficiency tests are of greater value; in hiring unskilled workers the capacity tests are more useful. Ideally, however, both types of tests are used for hiring all kinds of personnel, in order to give the administrator an adequate picture of the potential value of each applicant.

Tests are further classified as to whether they are administered individually or to groups, and whether they are done with paper and pencil or with the aid of instruments. In general, the group tests are of greater value to hospitals because they are less expensive than are the individual ones; for the same reason the use of paper and pencil tests is advisable in the selection of hospital employes.

We have established the advantages of using tests, and we have decided that we are going to use tests of capacity and proficiency, administered to groups that perform with paper and pencil only. How do we make sure that the tests we select are good tests; and how much do they cost?

After the tests to be used are selected the process of "testing the tests" takes place, that is, determining that the tests measure what they are supposed to measure, consistently and accurately, and that they actually predict success on the job. The consistent measurement of the same factors is called *reliability;* the accurate prediction of success on the job is known as *validity.*

CONTROL GROUP NEEDED

The first step is to procure a control group: a number of workers performing the same job. We administer the tests to this group, allow a certain length of time to elapse so that memory will not influence the result of the retest and then administer the test to the same group a second time. If the scores have remained the same, or quite similar, the tests are reliable. In order to ascertain validity, we must examine the relation between test scores and the success of each member of the control group on his job.

Job success is the *criterion* against which the test scores are weighed. If the criterion and the test scores are highly correlated the test is valid. The most readily available criterion is a rating by the supervisor or department head. One method of rating which is both simple and quite useful is a five letter scale, that is, rating each of the employes in the control group

Prepared by
ELSIE O. BERGMAN, PH.D.

REVISION OF ARMY ALPHA EXAMINATION

FORM A

Name ..... Date .....
Address ..... City ..... State ..... Age ..... Sex .....
In what country or state born? ..... Years in U. S. ..... Race .....
Draw a circle around the highest grade of school reached.
Grades 1, 2, 3, 4, 5, 6, 7, 8; High or Prep School, Year 1, 2, 3, 4; College, Year 1, 2, 3, 4.

Occupation:	From		To		Weekly Salary
Present	Month	Year	Month	Year	$ .....
Preceding	Month	Year	Month	Year	$ .....
Preceding	Month	Year	Month	Year	$ .....

Remarks .....

TEST 2

Get the answers to these examples as quickly as you can.
Place the answer to each example in the parentheses after the example.
Use the side of this page to figure on if you need to.

SAMPLES
1 How many are 5 men and 10 men? ..... Answer (15)
2 If you walk 4 miles an hour for 3 hours, how far do you walk? ..... Answer (12)

1 How many are 60 hats and 5 hats? ..... ( )
2 If you save $9 a month for 3 months, how much will you save? ..... ( )
3 If 48 men are divided into groups of 8, how many groups will there be? ..... ( )
4 Mike had 11 cigars. He bought 2 more and then smoked 7. How many cigars did he have left? ..... ( )
5 A man walked 8 miles and then walked back 2 miles. How far was he then from where he started? ..... ( )

TEST 4

If the two words of a pair mean the same or nearly the same, draw a line under same. If they mean the opposite, or nearly the opposite, draw a line under opposite. If you can not be sure, guess. The two samples are already marked as they should be.

SAMPLES	good—bad	same—opposite
	little—small	same—opposite
1	no—yes	same—opposite
2	day—night	same—opposite
3	go—leave	same—opposite
4	begin—commence	same—opposite
5	bitter—sweet	same—opposite
6	assume—suppose	same—opposite
7	command—obey	same—opposite
8	tease—plague	same—opposite
9	diligent—industrious	same—opposite
10	corrupt—honest	same—opposite
11	toward—from	same—opposite
12	masculine—feminine	same—opposite
13	complex—simple	same—opposite
14	sacred—hallowed	same—opposite
15	often—seldom	same—opposite
16	ancient—modern	same—opposite
17	enormous—gigantic	same—opposite
18	confer—grant	same—opposite
19	acquire—lose	same—opposite
20	compute—calculate	same—opposite
21	defile—purify	same—opposite
22	apprehensive—fearful	same—opposite
23	sterile—fertile	same—opposite

THREE TESTS, in small sample, are shown; all are from the Psychological Corporation. Above, left, is a portion of the Bergman revision of the Army Alpha Examination, which came out of World War I. Based on these examinations more practicable new tests have emerged. Above, right, is a modern type of test, as is the single item shown below from a test of mechanical comprehension. Hospitals associated with universities can borrow professional aid in selecting tests and training someone to administer and interpret them. Test materials should not be used by persons who lack reasonable training.

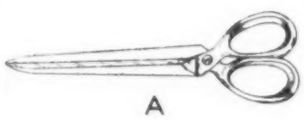
TEST OF MECHANICAL COMPREHENSION FORM BB

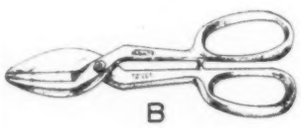
George K. Bennett and Dinah E. Fry

DIRECTIONS

Fill in the blanks on your ANSWER SHEET Write your last name first, the date, your age in years and months, and your school. Now draw a circle around the highest grade that you have finished in school.

Now line up your answer sheet with the test booklet so that the "Page 1" arrow on the booklet meets the "Page 1" arrow on the answer sheet. Then look at Sample X on this page. It shows pictures of two rooms and asks, "Which room has more of an echo?" Room "A" has more of an echo because it has no rug or curtains, so a circle is drawn around "A" on the answer sheet. Now look at Sample Y, and answer it yourself. Draw a circle around the right answer on the answer sheet.





Y

Which would be the better shears for cutting metal?

11

If the upper wheel goes in the direction shown, in which direction will the lower wheel go?

with an "A" for excellent performance, a "B" for good work, and so forth down the scale to an "E" for extremely poor work.

The next task is to separate the test scores into five groups, ranging from highest to lowest, for comparison with the ratings of the supervisors. If the ratings and the test scores jibe in most cases, the test is valid. Validity, then, is the measure of how often good employes have high test scores and poor workers have low test scores. The oftener this relationship occurs, the more nearly valid is the test.

The method of validating the tests described is simple and fast, although only fairly accurate. It should be mentioned that validation technics range from this quick way to the more highly involved statistical methods which are more nearly accurate and therefore preferable. This is not the place for a description of the latter —any standard work on statistical method will give a detailed description and explanation.

After the test has been validated it is ready for use in selecting employes. The test program has been installed; we are confronted with its maintenance. The first precaution that must be taken is to maintain standardization. Tests are, by definition, standardized samples of the individual's behavior; in order for them to be of any value they must be administered under standard conditions. It is best to use the same room for testing at all times. In this way, the light, heat and ventilation will be fairly constant and the element of comfort should

have little effect on tests and the results they reveal.

Many psychologists advise administering the tests at the same time of day to each group, in order to eliminate the variations in results often caused by fatigue and similar factors. The attempt at standardization of conditions can be carried to extremes, involving considerable needless expense. Suffice it to say that whatever conditions prevail at the time of initial test administration they will yield satisfactory results if they are continued in all subsequent administrations.

HOW TO GET COOPERATION

The second important factor in test administration is *motivation.* This can best be described as the attitude of the person being tested toward the test and toward his performance on it. Obviously, if he has little reason to do well, his results will be poorer than will those of another applicant who has every desire to make a high showing. Motivation has a great effect on test results. In order to control this factor as much as possible, it is best to follow certain basic rules in administering employment tests.

First, it helps considerably if the applicant knows why he is being tested and can see the relation between the test and being selected or rejected for the job. Normally his desire to be hired will constitute a high level of motivation. Second, it is important to make all test instructions clear—an applicant who knows what he is supposed to do and how he is supposed to go about it will perform much less hesitantly than will a confused one. Third, and perhaps most important, is the effect of the tester's personality.

It is best to have the tests administered by a likeable person with a smooth disposition and an even temper, so that the reaction to his personality of the persons being tested will be fairly uniform and sufficiently favorable to allow for good performance. Another equally important reason for consideration of the tester's personality is that the applicants he handles are, in most cases, members of the community from which the hospital receives much of its support and recruits many of its employes. The public relations value should always be considered particularly when rejecting applicants on the basis of low test results; the same good human relations technics must be employed here as elsewhere in the handling of applicants and employes.

Cost is our next consideration. We have chosen group tests, done with paper and pencil; the cost of these is nominal. In the case of standard published tests, forms can be obtained at little expense. And the cost of having your own test printed is no more than for other printed business forms the hospital uses every day. Chief expense is the salary of the person administering and evaluating the tests.

It is not necessary to consult industrial psychologists, although their professional services are of great value. Many industrial firms have had their testing programs installed and administered by a member of the personnel department—and hospitals that use tests usually follow this formula, with great success. In the case of a hospital that does not have a personnel department, it is quite feasible to assign the testing function to the individual who has been handling employment. If he has had little training in psychology, some research and study can teach him enough to set up a fairly competent testing program. This was done in one well known hospital and the results obtained there testify to the feasibility of this method.

Cost is not as prohibitive as one would think. Many industrial firms agree that the average cost of their testing program is approximately $1 per person tested. Considered in the light of the increased efficiency competent personnel can ensure, the decrease in costs due to turnover, and the decrease, which invariably accompanies better selection, in accidents and mistakes, this cost of $1 per person is negligible.

Employment tests have their limitations. There are factors left unmeasured, and some errors in measurement. Even the best test cannot predict with perfect accuracy in every case. Nevertheless, a sound testing program can be of infinite value. The money it can save will be a source of satisfaction to the cost accountant. The efficiency it can promote will be a constant pleasure to the administration, the staff and the patient.

FOR NURSES' TRAINING CATCH THEM YOUNG

THE girl of 15 or 16 has already been intellectually mature for one or two years, and there is nothing which a girl of 19 can learn of which her sister of 15 is incapable. Many suitable girls of 15 desire to become nurses, but because (in some schools) they have to wait till 19 they go into other occupations and stay there. Yet the girl of 15 is so pliable and enthusiastic that the atmosphere of a great nursing college could completely captivate her until she was 20. She will by that time have mastered a profession which will stand her in good stead as an insurance policy against any possible accident to her husband in later years.

If a girl starts nursing at 19 she feels as if she is taking the veil. She will finish her training at 24 or 25 and all this time she has the unhappy feeling that the best years of her life are slipping away. This, of course, only applies to the average nurse. There will always be some excellent women who feel that nursing is their vocation and who have determined to remain nurses throughout their whole life.

The objection that the public will not have confidence in a young doctor or nurse rests on the most superficial psychological grounds. Indeed, the nurse's uniform appears to be designed to make her look 10 years older than her age, a fact which favors the girl of 16 but greatly depresses the girl of 26. A youthful manner results from mental rather than physical factors, and the graduate at 21 who has been treated as an adult and not as a child will feel and look mature.—THE LANCET.

BLOOD BANK

Here nurses have taken over transfusions under supervision of part-time physician

AUGUST B. KORKOSZ, M.D.
Director of Blood Bank
Ellis Hospital, Schenectady, N.Y.

THE blood bank at Ellis Hospital, Schenectady, N.Y., was established in 1940 at the request of the surgical and obstetrical staffs. Its initial purpose was to expedite blood transfusions for emergency cases. Soon, however, elective blood transfusions were added and these have always constituted the majority of the transfusions.

Because of the ready availability of the blood, the number of transfusions steadily increased. The use of blood was given a great impetus as a result of war experiences as is graphically illustrated on page 74. The rapid rise since 1945 is probably due to the increased use of blood by returned veteran physicians.

The blood bank at present is under the department of pathology; the personnel consists of a part-time physician supervisor, five nurses and one technician. The nurses have staggered hours and administer the transfusions between 7 a.m. and 11 p.m. Between 11 p.m. and 7 a.m. blood transfusions are handled by residents and interns. The technician performs blood groupings, matchings and Rh determinations on a full-time basis between 8 a.m. and 5 p.m. Outside these hours the groupings and compatibility determinations are performed by a technician on call for the department of pathology.

Our nurses handle all steps involved in the transfusions and, following insertion of the needle, remain with the patient for twenty minutes to watch for reactions. The complete handling of transfusions by nurses has resulted in increased efficiency in administering transfusions and proficiency in venipuncture. In addition to handling transfusions the nurses administer all plasmas and intravenous solutions, excluding medications. This has resulted in greater expediency in intravenous therapy and lessening of the amount of work for interns.

About two years ago we began using disposable tubing and filters for recipient sets. As a result of this change we were able to transfer one worker who cleaned the nondisposable items in addition to making up the donor sets and performing other duties. This has had two beneficial effects: (1) we were able to manage the department more economically, and (2) one source of possible pyrogenic reactions was removed, namely, the recipient apparatus. It had been our experience that with every change of personnel handling recipient apparatus there had been a prompt temporary increase in pyrogenic reactions.

Every donor is questioned as to previous illnesses in general and specifically for past history of syphilis,

The top shelf of this refrigerator contains Rh negative blood and Witebsky antibodies. Lower shelves contain typed and matched blood.

malaria, hepatitis and acute infectious diseases. Donors with past histories of these diseases are not used. All veterans of World War II who were in malarial areas are questioned for obscure undiagnosed fevers. If this history is obtained, and if the veteran has not had symptoms or treatment for malaria, a thick blood smear is done. If this is negative for malarial parasites he is considered a suitable donor.

To date we have not had a single case of transmission of disease by blood. This, unfortunately, is not the case with the use of government-released plasma. In 1947 we administered a total of 1176 units of plasma and had three known cases of hepatitis, one of which was fatal. In addition we had an overall pyrogenic and allergic reaction rate of 5 per cent which was in sharp contrast to a reaction of about 0.01 per cent with our "home-made" plasma.

We keep thirty units of blood on hand. Usually, there are four units of group O Rh negative, about fifteen units of group O Rh positive, about six units of group A Rh positive, and the remainder, B Rh positive. The exact number of units in each group varies slightly from day to day depending on daily demands of the various groups and character of replacements.

We have two sources of replacement of blood. About 55 per cent of blood is obtained from friends and relatives of recipients. The second source is professional donors. We have an index of approximately 500 professional donors who are easily available. The professional donor list is kept large to have available an adequate number of replacements for those days when an unusually large number of transfusions are given and also to have an adequate number of Rh negative donors available for those cases needing multiple transfusions of Rh negative blood within a short time, such as bleeding ulcers and ectopic pregnancies with hemorrhage. The number of transfusions given varies considerably from day to day, the extremes being one and thirty for a twenty-four-hour period. There is no seasonal fluctuation. The peak month varies with each year and no definite conclusion can be reached as to the influence of season on the number of transfusions.

The administrative charge for the first blood transfusion is $10. This includes the services of the nurse for handling and giving the blood, as well as the cost of disposable material per transfusion, cost of handling donor tubing and bookkeeping. For each subsequent transfusion there is an administrative charge of $5. The patient is charged separately for the cost of the blood, *i.e.* $25, which represents the amount we pay professional donors. Separate charges made per transfusion are $3.75 for blood grouping, cross-matching and Rh determination for the first transfusion, and $1.25 for each subsequent transfusion for cross-matching.

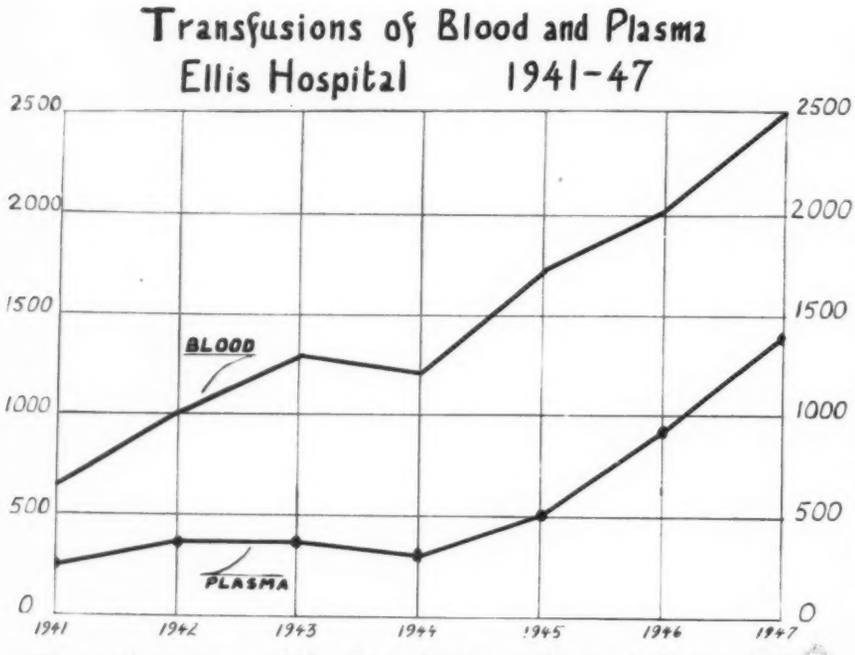
All blood is typed and grouped both for Rh and group compatibility. In selecting donors, the hospital excludes the less commonly used groups.

With each transfusion the patient or relatives are notified that a charge of $25 is being made for the blood alone and that this charge can be canceled if the blood is replaced by a friend or relative of suitable blood group. By selecting donors we can choose only those for whose blood we have use and exclude the less commonly used groups, such as AB and B. Our practice is in distinct contrast with that of other hospitals which require a two-for-one replacement. We feel that our system is equitable and works satisfactorily.

There is a slight but definite loss in the handling of the blood. We routinely perform Wassermann and Kline tests on all blood handled. Occasionally blood is drawn before the report is known and a unit of blood with positive serology must be discarded. This has accounted for the discarding of 14 units of blood since 1940. This is not a loss to the hospital inasmuch as the donor is notified that his blood is not suitable, the cause is explained, and credit is denied. One unit of blood was heated in a water bath in the early days of the blood bank and prompt hemolysis took place.

In a seven-year period about twenty units of blood were lost through failure of proper refrigeration, dropping of the blood, clotting of the blood within the container, and through overaging of blood. The maximum age for blood is seven days. The greatest part is distributed within four days after being drawn, the peak being the third day.

Pyrogenic and allergic reactions vary in percentage between 1.6 and 6.4. The reduction in reaction rate from that in 1941 and 1947 (prior to introduction of Rh factor and disposable tubing) has not been commensurate with the improvements. The most serious and dreaded hemolytic reaction has occurred twice in approximtaely 15,000 blood transfusions. In one case it was due to Rh incompatibility and in the other case the cause could not be determined No fatality resulted from either of the two hemolytic reactions. There is no mortality rate associated with the pyrogenic or with allergic reactions.



The rapid rise in use of blood transfusions at this hospital since 1945 is due to the increased employment of blood by doctors back from war.

In a previous paragraph it was noted that in 1947, 55 per cent of the blood was replaced by friends and relatives of patients. In 1946 friends and relatives replaced 67 per cent of the blood used. We cannot account for this diminution in the amount of blood replaced. Most of the patients questioned state that they do not have enough friends or relatives or do not want to go to the trouble of asking for replacements.

EXCHANGE WITH OTHER HOSPITALS

Several other services are rendered in addition to supplying the needs of hospital patients. Blood and plasma are furnished to several nearby small proprietary hospitals, to the Schenectady Isolation Hospital which handles only communicable diseases, and, on rare occasions, to hospitals in nearby cities which may need some unusual blood group in an emergency case. We feel sure that in case of large-scale catastrophe we can call on the blood banks of nearby cities to furnish large quantities of blood.

Recently we have been obtaining blood from the blood bank of the Post-Graduate Hospital of New York City. This service has been satisfactory and has diminished considerably the amount of work involved in replenishing blood. It saves approximately half an hour of work for each unit of blood ordered when all time is counted in handling a professional or a replacement donor, *i.e.* looking up names in an index, calling for donors, typing and drawing of blood. In addition to facilitating our work this service adds another large source of blood which can be called upon in case of emergency.

The foregoing is a brief description of the type of work done in our hospital. The general principles are standard for all blood banks in this vicinity but the exact type of service rendered depends considerably on the local conditions, the most important of which is the size of the hospital. The smaller hospitals maintain a supply of plasma on hand for emergencies and call on the nearby hospitals for blood which is furnished at the price charged at the hospital.

STATE AID IS AVAILABLE

Some small hospitals maintain a "walking" blood bank, which consists of a list of donors who volunteer to donate blood without charge at any time. One hospital supplies blood without charge to all patients. The funds for operating the blood bank are appropriated by the county and the blood is drawn from voluntary donors of the community recruited by a hard working committee of local citizens. The great majority of hospitals in this locality use a system of maintaining the blood supply that is generally the same as ours.

There are several trends at the present time which may alter the administration of blood banks in the future. About one year ago it seemed probable that drawing and free administration of blood in New York State might be taken over by the New York State Department of Health. State aid is now furnished to those hospitals in need of a blood bank and desirous of the aid. To date this blood bank has had no occasion to use this help and has been self-sustaining.

It will be interesting to follow the progress of the recent entry of the Red Cross into the field of blood banking on a permanent country-wide peacetime basis. Several "pilot plants" have already been established in several larger cities. If the eventual scope of this plan is realized the service rendered may very well be a substantial one not only in the collection and distribution of blood and blood substitutes, but in making readily available means of coping with local catastrophies of considerable magnitude whether of civilian or military origin. In the present unsettled times this must be borne continually in mind.

SANATORIUM PEOPLE live under tensions

So do factory workers. As problems in human relations, the two groups have similarities

JULIUS A. ROTH
Chicago

The author became ill while studying at the University of Chicago and was hospitalized in a private tuberculosis sanatorium, where he found physicians behind the times in their understanding of human relations. Hospital authorities would do well to look into the results of investigations carried on by research workers in the field of industrial relations, he says in this article which no thoughful administrator can afford to overlook.

—The Editors

WHILE I was taking William Whyte's course, "Human Relations in Industry," I read the report on the Tremont Hotel study which he directed. This project was a deliberate attempt to apply to a practical industrial situation the principles which had evolved during the many years of industrial relations research. As I read the report I was impressed by the parallels between the human relations problems of an industrial unit and those of a tuberculosis hospital.

I had already spent a short time in a county sanatorium and a long period in an army hospital and a veterans' hospital for tuberculosis. At the time that I read the Tremont study, I had completed the first few weeks of my present stay in a private tuberculosis hospital. Many of my experiences in these hospitals bear a close resemblance in type to the situations described in Tremont Hotel and other industrial studies. I believe that the same solutions to problem situations might, with modifications, be applied to a tuberculosis hospital.

Directors and physicians of TB hospitals are amazingly ignorant of the nature of the interpersonal problems of their patients, and they tend to dismiss them as individual idiosyncrasies. The nurses show a considerably better insight into their patients' problems, probably because they are close to them.

When a patient gets drunk, sneaks out, starts arguments, violates rest rules, or leaves the hospital against advice, the doctors usually know no answer except to exert their authority and attempt a tighter enforcement of regulations with the result that tension is increased and the patients become even more dissatisfied. The doctors make no attempt to investigate the reasons behind this overt behavior. This may be partly explained by the fact that they are hard pressed for time. However, I believe an even more important reason is that they do not recognize the nature of the problems involved.

Keeping people with active tuberculosis in a hospital and keeping them reasonably calm and inactive is an important public health problem, as well as a factor in the health and happiness of the victims. This aim can be accomplished only if the staff of TB hospitals (especially the physicians and directors) is educated in the problems of the human relations of a hospital society. The skillful handling of these problems is as much a part of the treatment of tuberculosis as are collapse therapy, bed rest and streptomycin. The best medical care available is simply wasted if the patient is so discouraged by his personal relations and emotional problems that he gets drunk every night or leaves the hospital against advice.

The following is a brief discussion of some of the aspects of human relations in a tuberculosis hospital, especially as related to industrial relations research.

It has been found that restriction of output is a common practice among workers. There is generally an informal, often unspoken, agreement among a group of workers that a certain amount of work is a "day's work" and no worker who has any consideration for his fellows should exceed it. A worker who disregards this agreement is likely to find himself ostracized by the other members of the group.

Supervisors usually react against restrictions (when they are aware of them) and try to break them so as to increase production. However, their efforts, whether coercive or otherwise, almost always fail. This discovery makes it appear questionable whether it is possible or even desirable to abolish restriction of output.

The expected task of a tuberculous patient is lying in bed. Just as the worker restricts his work, the patient restricts his bed rest. In fact, the violation of rest rules is so universal that any patient who observes them strictly

is assumed to be either very ill or somewhat "peculiar." This attitude toward bed rest is held not only by the patients, but by most of the nurses as well.

Not long after the patient arrives in a hospital, he learns how to violate rules without getting "bawled out" too often. He can then take part in the group life—bull sessions, card games, and so on—and become an accepted member of the hospital society.

Just as the supervisors try to abolish work restrictions, so the doctors try to do something about bed rest violations. They continually warn the patients about the seriousness of their condition. They tell the nurses to be more rigid in enforcing the rules. They may even threaten to eject a patient from the hospital. Their efforts are no more successful than are those of a work supervisor.

THEY WON'T TELL

Industrial relations investigators have found that an important cause for tension is making a change affecting the worker without discussing it with him or without even letting him know about it ahead of time. When a worker is told to shift jobs without warning, he may resist and perhaps even quit though the new position has the same or higher status than the old one. Supervisors cannot understand such behavior and usually regard it as pure obstinacy.

Similar behavior can be noted in a hospital. The physician will come to a patient's bed and say:

"We had a conference yesterday and decided to give you pneumo."

The patient immediately becomes angry. "You can go to hell. Nobody's going to stick a needle into me."

Logical argument fails to convince the patient. The doctor walks away, sadly shaking his head. "We just want to do it for his own good. Why does he have to be so stubborn?"

Does the doctor ever ask himself how the patient might react if he were allowed to participate in the conference?

In an industrial situation tension manifests itself in the form of arguments, "blow-ups," and walking off the job. Such incidents are usually explained as personal idiosyncracies and supervisors make little or no attempt to discover what lies behind them. Only recently have research workers begun to understand the place of factors like status anxiety, autocratic control, and lack of participation in creating areas of acute tension.

Constant argument is almost a typical feature of a TB hospital. Patients continually quibble with the doctors, the nurses and the other patients. "Blowing up" is frequent—a patient becomes angry and flatly refuses to cooperate. Walking out of the hospital appears equivalent to the worker's act of walking off the job. Since a patient who leaves against medical advice may be a danger to himself and to those with whom he associates, the solution of this problem is important to public health. Here again, treating the arguments and uncooperative behavior as isolated incidents can lead nowhere. The factors producing them must be considered.

The University of Chicago investigators have paid a great deal of attention to tensions between supervisors in industrial situations. The relations between supervisors are undoubtedly an important factor in determining the smoothness of operation of the work group.

The hospital nurse corresponds in some ways to an industrial supervisor. The nurses really run all of the routine affairs and make most of the decisions. The doctors seldom meet the patients, except when they make rounds. The doctor lays down policy and may be appealed to when a patient gets no satisfaction from the nurses, just as a worker may appeal to the manager when the foremen fail to help him.

Upward communication has the same difficulties in a hospital that it has in an industrial plant. The head nurse and doctors hear what the nurses want them to hear and this is often far from the whole story. They never hear about most rule violations. Differences involving patients, nurses, and/or maintenance workers are usually settled in a direct and personal way which would be frowned upon by the head nurse and doctors if they knew about them.

TWO AGAINST ONE

Arguments between nurses are frequent. Sniping behind one another's backs is even more frequent. While discussing three of the older nurses, my present roommate put it thus: "When Jones and Evans are together, they tear down Wright. When Evans and Wright are together, they tear down Jones. When Wright and Jones are together, they tear down Evans." Dissension between the nurses is an important practical problem because it detracts from the quality of the service given to the patients. Nurses have been known to walk off the job as a result of a dispute, thus leaving the patients without care. A patient may have to wait for an answer to his "light" while the nurses bicker about whose job it is to take care of him. A mistake is usually followed by elaborate buck-passing.

Just as in an industrial plant, remarks about members of the staff generally cannot be accepted as objective statements of fact. Statements by the patients about the relative efficiency of nurses are usually better indications of personal popularity than of nursing ability. When one nurse gave a painful injection to a patient, the latter said with a shrug: "She's bound to make a mistake once in a while." When another nurse did the same, this patient yelled indignantly: "She practically tore my flesh apart. She never does anything right. Why don't they get rid of her?"

RESEMBLANCE TO INDUSTRY

These reactions do not mean that the first nurse is usually more skillful with a needle than the second. It means rather that the first nurse is well liked because she is friendly and permissive and enters fully into the informal life of the hospital while the second nurse is disliked because she is gruff, bossy and strict.

In the preceding paragraphs I have tried to draw a comparison between certain aspects of human relations in industry and human relations in a TB hospital. The question is: Are the resemblances superficial or are they due to the fact that they are the products of the same mechanisms? My previous and present experiences in tuberculosis hospitals have shown a striking resemblance to the industrial cases of Whyte that I read recently. It is a problem which may deserve further investigation.

Perhaps more valuable than a detailed, theoretic study would be an attempt to apply means of improving human relations and noting the results as Whyte did in the Tremont Hotel study. It might be possible to try giving the patients greater participation in running the hospital and in deciding on treatment. An attempt could be made to clarify the status of the nurses and other employes. The importance of a more friendly and tolerant approach could be stressed.

Perhaps meetings of the patients, nurses and other employes would prove of value. A little psychological training would help the doctors understand why a person who is not deathly ill cannot lie in bed twenty-four hours a day for a year or two.

PERSONAL RELATIONS

In considering the interpersonal relations of a TB hospital, there are, of course, many things which must be considered besides those which fit the analogy of an industrial situation.

In the first place, the mere fact that a person is forced to stay in a hospital for a long time is an important factor in his behavior. Of course, the stay in the hospital means different things to different patients. Some are near their family and friends; others are far away. Some have had their careers interrupted by their disease; others have no goals and would just as soon live in a hospital as elsewhere. Some can get passes often; others with a more serious condition can seldom get out. But whatever the significance to the individual, there is no doubt that many months in this small, socially self-sufficient community must be constantly kept in mind when considering the interpersonal relationships of a TB hospital.

I previously compared the nurses to supervisors. This analogy, however, holds only in respect to upward communication and the relations among nurses. The nurse-patient relationship differs from the worker-supervisor relationship in many ways. To begin with, the nurses are women, whereas most supervisors are men. This is an important difference, especially for the male patients. The lower status usually accorded women affects the behavior of the patients toward those who supposedly have charge over them. In addition, the nurses, especially the younger ones, become a factor in the complex of sexual attitudes and behavior which exists in a TB hospital.

The nurses usually appreciate the difficulty of spending long hours in bed (many of them had active tuberculosis themselves) and therefore make no great effort to enforce the rules. A nurse who attempts to enforce the rules strictly or who refuses to take part in the "kidding" or other informal relations with the patients soon finds herself so unpopular that her position becomes untenable. Nurses not only tolerate rule violations, but often participate in them. They may encourage a patient to get out of bed. They may drink with the patients, or play cards with them, or even have a date with one who doesn't have a pass from the doctor.

Relations between the nurses and patients are extremely informal. A young, attractive nurse who does a lot of "kidding" with the boys put it this way: "I don't know why we should always be professional around here. Do they expect us to walk into a man's room, take his pulse, and never crack a smile or fool around with him? That's all right when a guy is in the hospital for only a few days or a few weeks, but when a man is hanging around a place like this for a year or two, you have to help cheer him up."

The analogy between the factory situation and the hospital situation also falls down to the extent that the hospital comprehends a much greater portion of a person's life than does the factory. We must, therefore, consider separately the drinking parties, the constant gambling, the bull sessions (often late into the night), and the great (even for our society) preoccupation with sex, all of which play an important part in the hospital life. These activities are all manifestations of the tensions under which the hospital patient lives. They can be used as vehicles to trace his problems.

HANDLING THE TB PATIENT

INCREASING attention is deservedly being given to the psychological aspects of tuberculosis sanatorium management. The experiences of Todd and Wittkower, set forth in their article, "The Psychological Aspects of Sanatorium Management," in the *Lancet* for Jan. 10, 1948, outline a most commendable approach to the problem. These authors state that "to teach patients a new mode of life is one of the main functions of a sanatorium."

The state of mind of patients on admission is usually one of depression and anxiety, which is a realistic, normal reaction to a serious illness. Some patients, however, try to overcompensate for their depression either by being very cheerful—placing their hope in a miracle or a drug—or by defiance, which represents an inability to accept dependence, or a strong social conscience regarding their obligations to family and friends. Others show open resentment and excessive sensitiveness owing to the inflation of self-interest common in chronic illness.

The effects of sanatorium life, which requires adjustment to a new world, are reflected in the mood of patients. If general morale is good, the mood is usually optimistic. Many patients enjoy the feeling of dependence which regimented care forces on them; such persons often exhibit childish reactions. They are in danger of developing what we in the United States colloquially call "hospitalitis." Others resent the loss of independence and counter it by taking too active a part in medically permissible activities. The need for affection which is present in all sick people is also mentioned and can be partially answered by encouraging normal social intercourse between men and women rather than by strictly isolating the sexes.

In meeting these problems, Todd and Wittkower counsel against autocratic sanatorium management, favoring instead the democratic approach in which self-imposed discipline of mature adults governs behavior. They stress the importance of tact in doctor-patient relationships, particularly the initial meetings; the desirability of giving patients all the medical facts of their condition, and the need for treating the personality as well as the lungs. At the time of discharge a heart-to-heart talk between the superintendent or his delegate and the patient is essential.

The authors do not mention the rôle of social workers, nor do they specifically discuss rehabilitation during or after sanatorium care. Their scheme does not include a staff psychiatrist, such as many of our up-to-date sanatoriums provide. The importance of a psychiatrically oriented treatment program is, however, clearly demonstrated throughout their well organized presentation.—EDWIN L. DEMUTH, M.D.

Introducing a Better Way

TO PROCESS SURGICAL GLOVES

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Strong Memorial Hospital
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FRANCIS W. BISHOP
Strong Memorial Hospital
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PREVIOUS to the establishment of a "glove department" at Strong Memorial Hospital, Rochester, N.Y., employes worked full time patching, powdering and wrapping the surgical gloves.

The nurses on duty in the operating rooms washed and tested the gloves and also helped with the wrapping because two people could not keep up with the daily demand.

Looking back to that era, the testing by itself seems to have been an endless job. After the gloves were washed and dried, all nurses who happened to have a minute to spare sat around a table blowing them up, fanning them in front of their faces, searching for holes. The good gloves were put into one box and the ones with holes, into another. The latter were brought to a room where the two employes tested them again, trying to find the holes and to patch them. Many of the gloves had several holes (pinholes) and, once patched, the gloves could not be tested again until the following day when the patch was dry.

They were then brought back to be tested again by the nursing staff before being wrapped and sterilized. After this first attempt at patching, about 80 per cent still had holes and had to be sent back. Now that we have a mechanical tester that locates all holes in one operation we can understand why so many had to be returned.

In addition to these two full-time employes, it seems that gloves were done all day by everyone, and because of the lack of direct responsibility and supervision, the job often was not performed as carefully as it should have been. Furthermore, it is quite hard in manual method to avoid injuring the rubber by the twisting necessary to retain the air, and presumably some of the holes found afterwards in the wrists were the result of such twisting.

Another annoying feature was that the operating rooms never seemed able to keep the necessary number of sterile gloves on hand and much time and energy were spent in borrowing.

This difficulty has vanished since the glove department was created, in spite of the fact that nearly double the number of gloves is now in use because of a change in surgical technic.

The care of rubber gloves is a tedious job, and to make it easier, pleasanter, much faster, and probably safer, it seemed desirable to find a way of washing, drying, testing, patching and powdering them by mechanical means as far as possible. The manual method of washing and drying gloves is too well known to require description. The mechanical method which we have been using for the last two years is as follows:

After preliminary tests with some especially dirty gloves in a small apartment-sized machine, a larger washing machine was purchased and slightly modified and the following technic was worked out:

Fill washing machine with cool water and submerge gloves (about 200 gloves can be done at one time). Wash for two minutes and drain. Fill washing machine with warm water, wash gloves for two minutes and drain. Fill with hot water and add one cup of liquid soap or other detergent and wash for two minutes. Drain and rinse twice with warm water in the same manner as the two first rinses. Remove gloves from the washing machine, taking about a dozen at a time, holding them by the fingers in order to drain as much water as possible. It may be noted that the soiled gloves need not be touched by human hands until the washing is complete.

The gloves are then put on a conveyor belt and pass through a special wringer one by one, fingers first, and are then spread out on a table covered with a treatment blanket or any similar soft cloth for inspection.

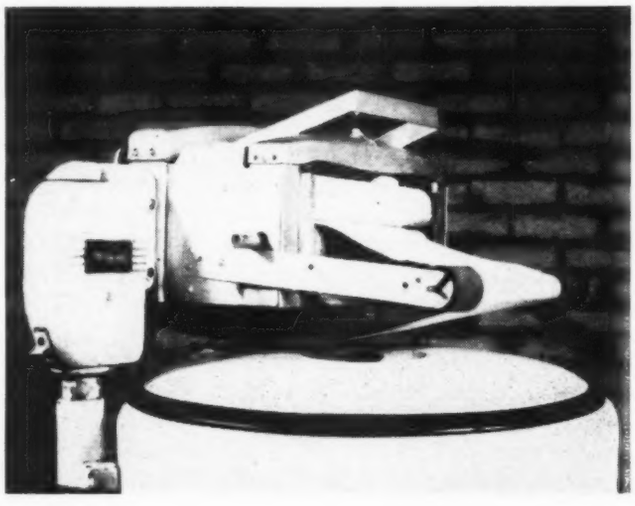

Fig. 1 — Top of washing machine and modified rollers as described in text.

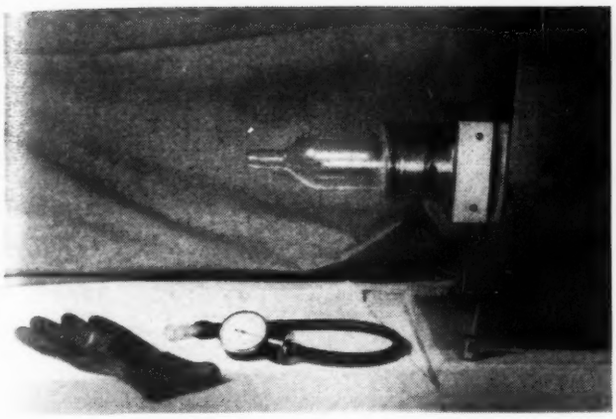

Fig. 2—This setup shows the lamp housing assembly and the accessories.

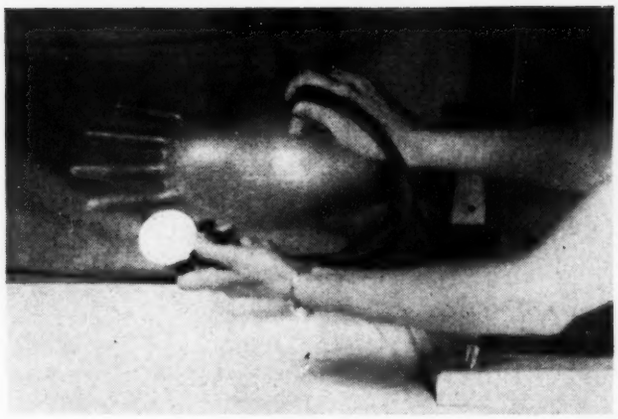

Fig. 3—Here a glove is under test. The manometer is checking a suspicious spot.

The principal modification of the washer has been the addition of a duplicate set of rollers mounted in tandem. (Fig. 1.) The back rollers are the original powered set, and the new front pair is turned by the conveyor belt as it is pulled through the powered rolls. The gloves thus get a double wringing and are essentially dry when they come through. The upper roller is covered with a canvas sleeve to prevent the gloves from sticking as they tended to do on the original rubber roller.

Experiments have been made with some of the automatic washing machines, but although the gloves were clean, the whirl-dry systems did not remove the water from the fingers. The washer chosen has a reciprocating paddle wheel, but it is expected that a plunger type would work equally well. It is comparatively simple to make this machine completely automatic as far as changing the water and rinsing are concerned.

One cannot help noticing the shine and glow of cleanliness when the gloves are laid out, in contrast to the dull mass of rubber when they were washed by the former method. They seem to puff up and really appear new again. Bacteriological tests made after washing in the machine have all proved negative.

The gloves are now ready for testing, patching if necessary, and powdering.

In order to facilitate the testing and patching of the gloves, an illuminated, pneumatic apparatus was constructed. (Fig. 2.) It consists of a large lamp housing, to which is attached a 2½ inch glass tube, about 5½ inches long, the end of which is drawn down to accommodate the fingers of the gloves. A simple ring clamps the cuff of the glove to be tested. The large end of the glass tube is sealed by a window, through which the light is transmitted. Compressed air is admitted to the glove through the open small end of the tube. The amount of inflation is controlled by a foot valve. When the gloves are inflated, the illumination available makes any pinholes easily visible. A bell stethoscope with a single rubber tube attached to a manometer can be used to distinguish between a pinhole and a transparent spot on the glove, if there should be any doubt. Any holes found are marked by lipstick on the end of a glass tube. (Fig. 3.)

Fingers are tested individually by sliding them over the drawn-out portion of the glass tube and are marked in a similar manner. The ring and clamp which holds the gloves can be rotated, allowing inspection of any portion of the wrist, hand and fingers of the glove.

Gloves with the holes marked as described are patched easily and quickly by liquid rubber from a special dispenser which is touched to the spots in question and allowed to dry overnight. The gloves are then ready for powdering.

The *manual* powdering of the gloves was performed in a rectangular box the top of which had a large window. The front of the box had two holes with cloth sleeves through which the arms could be passed into the interior of the box. A few gloves were put into the box and rubbed around in a quantity of loose powder on the bottom. They were then reversed and the procedure was repeated. The gloves were then paired and were ready for sterilization. This method, while effective, was slow and tiresome.

In the mechanical method, the gloves are paired and clamped together at the cuff in advance since they do not have to be reversed during the powdering.

The powdering machine consists of a sheet metal box 15 by 15 by 15 inches with a fairly tight removable cover. Some 100 to 120 gloves are placed within this box together with one to two cups of loose powder. The box containing the gloves and powder is placed within a cage, one side of which is hinged for the purpose. The cage is used in a subsequent step for removing the excess powder from the outside of the gloves. The metal cage has welded to it two shafts, extending from diagonally opposite corners. The shafts are mounted horizontally in bearings in the side of a larger wood box which is cut through at its equator and hinged. The top half of the enclosing wood box has large plastic windows through which the cage containing the sheet metal box can be observed.

The cage is rotated at a speed of about 50 r.p.m. by means of a motor. The paired gloves and powder are tumbled for about five minutes to make sure the insides up to the finger tips are adequately dusted. This means that the outside of the gloves often has more than the desirable amount of powder. Therefore, the cover of the metal box is removed, the door of the cage is closed, and the gloves are allowed to tumble for an additional two minutes. The unused or excess powder falls into the larger wood box, the bottom of which is

made in the shape of a funnel, and into a bag to be used over again.

A small edition of this powdering apparatus is used in sections where only a few gloves are processed. (Fig. 4.) The procedure used is similar.

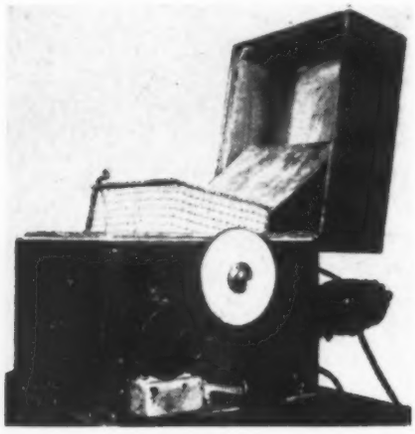

Fig. 4 — Small glove powderer.

The mechanical method of powdering gloves is the outgrowth of many experiments involving various procedures and has proved to be rapid, simple and reliable.

The application of a washing machine to the problem of the care of surgical gloves has resulted in a great saving of time and in addition has made it possible to turn this task over to relatively unskilled personnel. All nurses who were involved in any phase of glove handling are now freed to perform duties more in keeping with their capabilities. All steps from washing, drying, testing, repairing, powdering, wrapping and sterilization are now under the supervision of the central supply room. The cost of glove maintenance has greatly decreased and the supply of gloves meets the demand. The total number of employes now caring for the gloves is only three.

Some hospitals* are having their gloves washed in their main laundry but this institution has found that the method described has worked quite well. It eliminates the necessity of transporting gloves from one department to another and they are available in one place for all emergencies.

Many laundries, including ours, operate on a forty-hour-week, which means that they are closed on Saturdays, Sundays and holidays. Those days are often the ones with the highest accident rate, which in turn requires an extra number of gloves.

*Miller, Linwood: Washing Surgical Rubber Gloves, Mod. Hosp. 69:73 (November) 1947.

Here Are Specifications for Operating Room Supervisor

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Methodist Hospital of Dallas
Dallas, Tex.

EVERYTHING that is done in the operating room is for the benefit of the patient. There should be no other purpose. This is true for everyone connected with the operating room. The doctor, the operating supervisor, and her staff must work in harmony at all times. Each, insofar as possible, should know and understand the duties and responsibilities of the other. The doctor expects courteous consideration of his request for time, whether he is a so-called important doctor or a young doctor attempting to get started.

When a definite time has been allotted for an operation the doctor should make the incision at that time. This is especially true if he is to be the first operator in the morning. If he is late, he should be canceled out if the cancellation will not endanger the patient's welfare.

After the patient is brought to the operating room, there should be no actions or sounds to indicate that all was not in readiness. No one should be reprimanded in the presence of a conscious patient. The doctor expects the operating supervisor to see that the patient is placed on the table in the proper position. He then expects the supervisor to give attention to each minute detail of the chain of aseptic events occurring before and during the operation. The operating supervisor is expected to have a scientific attitude in regard to this work and to have the capacity critically to analyze and consider suggestions advanced by the doctor.

MUST PROTECT PATIENT

It is essential that the operating room attendants see that the patient is properly prepared and draped. If in the course of operation a complete change of plan is decided upon by the doctor for the patient's benefit, the supervisor should cooperate willingly and rapidly; even if this interferes with another doctor's time it should be done.

Doctors do not expect supervisors to treat them as if they were machines. One doctor performs an operation in his way in a given length of time and another doctor may do the same operation in his way in a different length of time. The doctor who takes up the least time is not always the one who performs the best operation and gives the best care to the patient. The supervisor should judge and allot time in the light of past individual performance and should consult the doctor about the time he needs.

The supervisor should protect the patient and the hospital from the doctor, if necessary. If all is not being done that should be done for the patient, the supervisor should notify the resident or the superintendent of the hospital. If from past experience she knows that the doctor may not be fully qualified to perform the operation, she should notify the resident in advance that this physician is operating and the resident should stand by.

MUST BE FAIR

Nurses, too, have certain views regarding the supervision of the operating room. They expect a cheerful, competent, clear and concise direction. When lines of responsibility are clearly down there will be a minimum of indecision and the major share of the work will not be borne by a willing few. When one member of the team loafs and constantly gets away with it under the eyes of the supervisor, other members of the team are unfavorably influenced.

Nurses do not expect to be embarrassed or belittled by the supervisor. The supervisor who embarrasses the new nurse, especially if this is her first time in the doctor's presence, and causes delay in the operation calls unfavorable attention to herself. The nurses expect the supervisors to be human beings and treat others as such. A supervisor should attempt at all times to bear the load of her responsibility without losing her sense of fairness and respect for the nurses who are working under her.

Presented to the Association of Operating Room Nurses, Dallas, Tex.

JOB STUDY POINTS THE WAY TO BETTER NURSING

RUSSELL C. NYE

Administrator
Northwestern Hospital, Minneapolis

IT IS the purpose of this discussion* to examine the objectives, philosophy and motives for the "new look" in nursing; to describe the methods that are now being developed, giving a few examples, and to point to the effects which such work as re-evaluating nursing duties may have upon health, education and economic welfare in our hospitals.

Because we are just working out of a dark period of nurse shortages in our hospitals, one of our objectives is to fill in the gaps of nursing service with trained subsidiary workers. To offset the diminished supply of graduate nurses, feasible changes in job assignments must be made. In our own hospital, a personnel survey aimed at making these changes is now completed, and we have given our director of nurses tools of management with which to work and at the same time recognize and maintain professional standards without "guess-estimates." I feel we have opened up countless possibilities for continuous evaluations and reassignment of job responsibilities.

In the planning stage these important people held strategic positions in getting the survey started: Dorothea Glasoe, director of nurses, Northwestern Hospital, Don Carner, assistant administrator, personnel manager and public relations director of Northwestern Hospital, and Art Hennings, assistant administrator, comptroller and budget officer of Northwestern Hospital.—RUSSELL C. NYE.

HENNINGS: The job analysis and personnel study we did at Northwestern Hospital first had to be explained to department heads. Then we met with representatives of labor organizations to gain their cooperation and suggestions. About twenty meetings were scheduled with groups of employes. These meetings were held on different days and at different times, varying from 8 o'clock in the morning to 11:30 at night. The reasons for job analysis were explained. It was emphasized that this was a study of jobs and not individuals.

Questionnaires were distributed to all employes who were asked a variety of questions concerning working conditions, hours, equipment used and responsibility for work of others. They were requested to record and classify job duties as to "daily," "periodic" and "occasional," the amount of time spent performing each duty, and whether or not supervision was received.

MISS GLASOE: Before the scheduled meeting, I attended the conference of department heads with the director of survey. Since the nursing department is one of the major divisions of the hospital and because of the nurse shortage, I welcomed the survey as a tool by which we could evaluate and redistribute nursing duties and responsibilities.

I attended scheduled meetings and answered questions as I could relative to the questionnaires. I had participated in another survey so this was not entirely a new experience.

It was not a simple procedure because it was necessary to review all employe questionnaires, to evaluate and make additions and corrections.

HENNINGS: I should like to interrupt at this point to suggest that in planning for a job analysis it might be well to consult with the director of nurses so that you don't start a job analysis when a new class of student nurses is beginning.

MISS GLASOE: You're quite right!

HENNINGS: Going on with the job analysis: Questionnaires were read and classified with job groups upon the basis of duties performed. Job duties were checked with individuals and department heads and the job descriptions were written. Jobs were then evaluated in terms of factors required to establish proper relationships among them. While we were busy working on the details of the job analysis survey, the nursing department was not sitting by and twiddling its thumbs. Miss Glasoe, take the ball.

MISS GLASOE: Well, I had been thinking about revamping the nurses' working day, and about the time the survey was started, I felt that one more new venture wouldn't break my neck. So we broke with tradition and established what is now known to us as the 8 o'clock day. We also transferred some of the duties formerly taken care of by the nurses to the increased number of subsidiary workers. Mr. Carner, through the patient opinion poll, what have you found to be the patients' reaction to this change?

CARNER: The patients' reaction to the transfer of duties is overwhelmingly favorable. Periodically, patient opinion is polled in the hospital and we have not had a complaint on this score. Another interesting fact disclosed through an opinion poll is the way in which the shift in the starting time of the hospital day met with widespread approval.

Last November the starting time of the hospital day was moved from 7 a.m. to 8 a.m. This served several purposes. The primary reason for the change of time was to adjust the abnormal hospital day as closely as possible to conform with the normal day of an average person. Most patients don't like to be waked at the crack of dawn and tucked into bed when the lights go on.

A secondary factor, but one of considerable importance, was to make hospital employes' working hours more

*Panel discussion presented at the Upper Midwest Hospital Conference, 1948.

nearly conform with the schedule followed by workers in most other fields of employment. Miss Glasoe, how was the "shift" accomplished in nursing without disrupting your organization?

MISS GLASOE: I might say that it was a cooperative venture, working with all departments. Again, a meeting of department heads was held to get their immediate reaction. Several weekly meetings were held and ground plans were laid. Letters were sent to all doctors explaining the plan. An explanatory card with an attractive caption was sent out by the nursing division. We thought perhaps the dietary division would find the change most difficult to introduce to its workers. But strangely enough, it was most enthusiastic.

I feel this is one of the most important changes we have made in nursing service and has definitely brought about the "new look" in nursing.

CARNER: Do you mean a "new look" on the faces of our nurses?

HENNINGS: There are several reasons for a new look on nurses' faces. Tasks were shifted; the more routine duties were given to subsidiary workers. These subsidiary workers were given "in-service" training to improve their efficiency. Ward clerks relieved nurses of some of the clerical duties. Fair and uniform personnel policies are being instituted. Suggestions asked for in the questionnaire resulted in minor improvements in routines and working conditions. And speaking of working conditions, we found that additional locker space was needed; then restrooms and lunch rooms were improved and redecorated and music was installed.

NYE: Has the installation of music piped into the employes' work areas been beneficial to the hospital?

CARNER: Very definitely! Installation of the system meant far more to our employes than just an opportunity to listen to music while they work, while they relax during their "coffee time," and while they lunch. It was, in addition, a real symbol to the employes of the interest the management takes in their work and in their working conditions. Our people are learning that we are most interested in them as individual members of a team whose goal is to provide a high quality of care to our patients at the lowest possible cost.

HENNINGS: I agree 100 per cent. The improved working conditions and management's manifest interest in the employe have resulted in a decreased labor turnover rate. During the first ten months of 1947 we had an average monthly labor turnover rate of 8.7 per cent, or a yearly rate of 105 per cent. In the first three months of 1948 this average monthly rate dropped to 6 per cent which is a 30 per cent reduction in turnover, and our personnel program has hardly begun to function. I might add that during the month of April this rate dropped down to 5 per cent per month. Research studies have indicated that it costs an average of about $80 to train an employe to do his job.

An example which we might cite is the nurse's aide. When a nurse's aide leaves our employ, we have to train a new individual for a week before she assumes her duties; this costs us a weekly salary plus the time of her instructors and supervisors. She will not be able to handle her job as well as her predecessor did for several weeks. This will mean that more supervision and more help will be needed. We have therefore been forced to pay for training time, additional supervisors and instruction. The work accomplished is less efficiently performed. When you consider all these factors, $80 begins to look like a conservative figure.

Upon this basis of $80 we estimate that we have saved $10,000 in training costs so far this year, of which about $5000 has been in the nursing department.

MISS GLASOE: The saving will come back in increased efficiency in the worker and, in time, this will result in personnel saving. Certainly, a careful in-training program and better personnel policies are going to attract and hold a higher type of individual and the labor turnover will be further reduced.

Reorganization on the administrative level has been of help. Formerly there were too many persons reporting to the director of nurses, according to good principles of business management. This number has been reduced from seventeen to eight.

Reorganization of nursing divisions with two stations per floor instead of three and a saving of one head nurse and one assistant head nurse on each floor achieves better supervision and justification for clinical instructors.

On staffing we find the ratio went something like this: 40 per cent graduate nurses; 40 per cent trained subsidiaries, including students; 20 per cent untrained subsidiaries.

We have provisions for sick leave and vacation relief.

We have found 3.6 hours per patient day necessary on medical and surgical floors. It depends upon the standard of service desired and the facilities in the hopital.

CARNER: Yes, and other benefits will include better supervision and an organization that will properly interpret personnel policies to the employes. The emphasis in our work might vary somewhat from that of personnel departments in other hospitals. We are going to stress human relations—the relations of one individual to another, the relationship between the worker and his immediate supervisor, the attitude of supervisors to their employes. We will try to understand the social organization of our hospital and to develop an appreciation of the pressures under which our people work in order to further consideration of each member of the team as an individual.

One might well raise the question of how the expense of such detailed interest in our employes can be justified. Economically, we know that we have been all but neglecting a $100,000 annual operating expenditure. Sixty-two per cent of our budget is allocated to salaries and we have not made a concentrated effort to ensure that we are obtaining value received for each dollar spent. We also know that we cannot expect poor quality, disinterested employes to produce a high quality of care for our patients.

Our personnel program will pay its way many times over each year and it will go a long way toward enabling us to provide the type of care our patients deserve and desire.

NYE: To wind this up: Inasmuch as research and operations work better as a team than they do separately, we have found that a new focus for interest, enthusiasm and ambition in nursing has resulted by widespread understanding and use of budgeting, statistical control and cost accounting—department by department. We feel that we will soon have established bases from which an even more fruitful and democratic relationship between nursing and administration will result.

"BRING UP AN ADMINISTRATOR—"

Commission Reports on the Way He Should Go

ONE who looks in on a hospital administrator at work, says Dr. Charles E. Prall, will find him carrying on three principal lines of activity —trouble shooting, reviewing and appraising results, and promoting the future program. In the last volume of the report of the Joint Commission on Education,* Dr. Prall explains in some detail the nature and amount of the trouble shooting that was done by the hospital administrators whose work was analyzed during the commission's studies.

MUST FIND SOURCE OF TROUBLE

"In many periods of hospital development this activity holds priority over the others. That is not because it may be considered an end in itself . . . but because a failure to spot and adjust troubles stands in the way of all other accomplishments. The malfunctionings of a hospital organism stem from a variety of causes. Some are organizational weaknesses in the main; they arise from friction between parts of the enterprise due to confused authority. Others are rooted in the presence of working associates with different outlooks or professional proclivities.

"Whatever the causes of malfunctioning may be, the administrator must be able to recognize the evidences from the mass of symptoms which assails him and he must be experienced in providing remedies. . . . All this is just another way of noting that in a complex enterprise there are likely to be pieces which refuse to stay in place."

Hospital administrators who can spare the time from their trouble shooting to read the commission report will find encouragement in the conclusion that whereas administration in hospitals has something in common with administration in other fields, it goes beyond other fields in the demands placed upon the chief executive.

Evidence of this may be found in the wide range of "curriculum areas" recommended for college courses in hospital administration, including medical staff, personnel management, departmental functioning, business and financial management, medical care, and community relations. Other areas recommended for inclusion in the study program are legal aspects of administration, plant planning and maintenance, statistics, purchasing, stores and issuance of supplies, and relations with governing boards.

There are three broad phases in the administrator's training today, the report indicates—the instructional year, the internship year, and the on-the-job training that the young administrator gets after he finds his place in the field. The part played by each phase is amplified in the report.

GREATEST GENERAL INTEREST

Possibly the section of greatest general interest in the present volume, however, will be Part III, which deals with two previously neglected subjects of considerable importance, the demand for new administrators in the field and the rôle of the assistant administrator.

As explained in an author's note accompanying this part of the text, Part III is not an official report of the commission, as are the preceding sections on curriculum and instruction, though it was read and released for publication by a special committee of the commission.

"Members of the commission often encountered a great deal of apprehension lest the field might soon be oversupplied with course graduates," the author explains. "Impelled by the need for more facts on this question, the executive committee proposed that a thoroughgoing study of placement opportunities be made."

Seventeen hundred hospitals were covered in the study of demand for administrators, the report explains. The hospitals ranged from seventy-five to 600 beds, and institutions under federal control and Catholic ownership or management were excluded. Among the 1700 hospitals, 365 had undergone a change in top executive some time during the twelve months preceding the survey. The demand for new administrators, it is pointed out, must be calculated by eliminating from the total number of changes those vacancies which were filled by administrators from other institutions. In this case, the resulting net demand was for 206 new administrators.

In adjusting the number of courses in hospital administration that should be offered and the number of students that should be accepted to the demand for administrators, the report indicates, consideration must be given to the rôle of assistant administrators.

"Each assistantship which a course graduate accepts will exercise a cushioning effect upon the adjustment of supply to demand," the author states. "The size and permanence of this equalizer should be known if training authorities are to make decisions intelligently."

COORDINATES DEPARTMENTS

In the study of assistantships that follows these facts emerge:

The commonest assistant's job involves the coordination of the work of several hospital departments, as in hospitals with several second line officers. The sole assistant to whom all department heads report is not unusual, but the arrangement has many disadvantages and is generally less satisfactory than the "territorial assignment" covering only stated areas, such as maintenance, housekeeping and laundry, or a rotation of responsibilities. Other assignments for the assistant include control, policy making, counseling and standing in for the chief executive.

*The College Curriculum in Hospital Administration. A final report by the Joint Commission on Education, American Hospital Association-American College of Hospital Administrators. Chicago: Physicians' Record Co., 1948.

SMALL HOSPITAL FORUM

THESE HOSPITAL SITES ARE SPACIOUS

MOST HOSPITALS ARE LOCATED ON SEVERAL ACRES OF GROUND IN DESIRABLE CITY NEIGHBORHOODS

THE average small hospital is located in a residential neighborhood of from good to excellent quality, occupying a little less than half of a 6 acre site. The remainder of the grounds consists of lawns, flower gardens, trees and shrubs, which are maintained by a hospital employe who spends a little less than full time on these duties. The hospital neighborhood is zoned against intrusion by undesirable industrial or commercial enterprises. In most cases, moreover, the hospital administrator or trustees take some interest in zoning, city planning and related activities as they affect the hospital.

All these facts emerged from a Small Hospital Forum on hospital sites. Twenty-three hospitals were covered in the survey, ranging in size from thirty-two to 141 beds. Average size of the hospitals is sixty-five beds. Communities in which the hospitals are located vary from a little town of 2000 to a city of more than 1,000,000. For the most part, the hospitals taking part in the survey are located in the East, Midwest and South.

IN CITY LIMITS

As shown in the table on the opposite page, all but two of the hospitals are located inside the corporate limits of the town or city served. In both cases where the hospital is outside the city limits, it is indicated that the site is just beyond the boundary, and that the surrounding area is already partially improved.

Size of hospital sites varies from a 100 foot lot, in one instance, to a plot of eight square blocks, or approximately 30 acres, in another. From the nature of the data furnished it is difficult to determine the exact size of all the sites, but an average of 6 to 7 acres is plainly not far from the truth, with the amount of the site occupied by hospital buildings pretty well determined by the size of the grounds. In this particular group of hospitals, sites are noticeably larger in the East and South than in the Midwest, but it is likely that the sample is too small to be significant geographically.

Twenty of the respondent hospitals described their grounds for the forum, with the following results: In every case, a large part of the grounds is occupied by lawn. All but two of the hospital sites also have trees; shrubs adorn fifteen of the twenty sites; flower gardens are added in

THANKS TO THESE CORRESPONDENTS

HOSPITAL	RESPONDENT
Community Hospital, Newark, N.J.	Romeo C. Gibbs
Wolfe City Community Hospital, Wolfe City, Tex.	R. L. Greenway
North Platte Memorial Hospital, North Platte, Neb.	Floyd E. Grady
Parkview Hospital, Plymouth, Ind.	M. Virginia McQueen, R.N.
Crossett Health Center, Crossett, Ark.	F. H. Owens Jr.
Emerson Hospital, Concord, Mass.	Elmina L. Snow
Edw. McCready Memorial Hospital, Crisfield, Md.	E. Blanche Hoffmaster
Americus and Sumter County Hospital, Americus, Ga.	J. G. Williams
Clarksville Hospital, Clarksville, Tenn.	Olivia Shortt
Brookings Municipal Hospital, Brookings, S.D.	Zella C. Missner
St. Peter's Hospital, Melville, Can.	Sr. Francis de Sales
Cohoes Hospital, Cohoes, N.Y.	Elizabeth Lautermilch
Columbia Hospital, Columbia, Pa.	Anna Belle McNeal, R.N.
Washington County Memorial Hospital, Bartlesville, Okla.	M. Gash
Radford Community Hospital, Radford, Va.	G. C. Poff
Grace Hospital, Cleveland	Leota L. Harnden
Hayswood Hospital, Maysville, Ky.	Alma I. Schiek
Lutheran Hospital, Sioux City, Iowa	Alfred Bieber
Sacred Heart Hospital, Medford, Ore.	Sister Luke
Windham Community Memorial Hospital, Inc., Willimantic, Conn.	Wm. B. Sweeney
Bethel Deaconess Hospital, Newton, Kan.	H. J. Andres
Memorial Hospital, Cheyenne, Wyo.	Z. E. Sevison
Ingalls Memorial Hospital, Harvey, Ill.	L. C. Mortrud

CHARACTERISTICS OF SMALL HOSPITAL SITES

Hospital Region	Beds	Inside City Limits?	Pop. of City	Size of Hospital Site	Pct. of Site Occupied by Bldgs.	Nature of Unoccupied Grounds*	No. Grounds Employes	Char. of Surrounding Area	Nature of Surrounding Improvement	Quality of Hosp. Neighbrhd.	Protected by Zoning?	Trustees in City Planning?
East	90	Yes	40,000	14 acres	10	lfts	1½	Improved	Residential	Good	Yes	Yes
East	37	Yes	7,500	13 acres	20	lfts	½	Improved	Residential	Excellent	Yes	Yes
East	38	No	6,300	12 acres	5	lts	½	Improved	Residential	Excellent	No	Yes
East	61	Yes	24,000	2 sq. bl.	50	lft	1	Built-up	Mixed	Fair	No	No
East	62	Yes	12,000	1 sq. bl.	25	lf-ts	½	Improved	Residential	Excellent	Yes	Yes
East	30	Yes	400,000	⅛ sq. bl.	98	—	½	Built-up	Mixed	Fair	Yes	No
Midwest	76	Yes	1,000,000	—	—	—	1	Built-up	Residential	Fair	—	No
Midwest	105	Yes	80,000	½ sq. bl.	50	_	½	Built-up	Mixed	Good	Yes	No
Midwest	141	Yes	22,000	1 sq. bl.	75	lfts	1	Improved	Mixed	Excellent	Yes	Yes
Midwest	33	Yes	5,700	1 sq. bl.	50	_	½	Improved	Mixed	Good	No	No
Midwest	100	Yes	12,000	1½ sq. bl.	66	lfts	1½	Built-up	Residential	Excellent	Yes	Yes
Midwest	45	Yes	6,000	1 acre	33	lt	1½	Built-up	Residential	Excellent	Yes	Yes
Midwest	32	Yes	15,000	1 sq. bl.	20	lf-ts	½	Improved	Residential	Excellent	Yes	No
Midwest	118	Yes	34,000	2 acres	70	lts	½	Built-up	Mixed	Fair	Yes	No
South	42	Yes	16,000	6 acres	10	lfts	1	Built-up	Residential	Excellent	Yes	Yes
South	74	Yes	12,000	1 sq. bl.	33	lts	½	Built-up	Residential	Excellent	Yes	Yes
South	82	Yes	12,000	4 acres	30	lts	1½	Built-up	Residential	Excellent	Yes	Yes
South	40	Yes	15,000	½ acre	25	lfts	½	Improved	Residential	Excellent	Yes	Yes.
South	72	Yes	30,000	1 sq. bl.	25	lfts	1	Built-up	Mixed	Fair	No	Yes
South	32	Yes	2,000	1½ sq. bl.	50	lt	1	Improved	Residential	Fair	No	Yes
South	35	Yes	7,500	⅔ sq. bl.	25	lts	1	Improved	Residential	Fair	Yes	Yes
West	87	No	17,000	8 sq. bl.	30	lfts	1	Built-up	Residential	Fair	Yes	No
Canada	60	Yes	5,000	4 sq. bl.	—	—	1½	Built-up	—	—	Yes	Yes

*l—lawn.
f—flower gardens.
v—vegetable gardens.
t—trees.
s—shrubbery.

eleven cases, and two of the hospitals also keep vegetable gardens.

In no case does grounds maintenance require more than one full-time and one part-time employe. (For purposes of convenience, the accompanying table shows all part-time employes as half-time, though this is not necessarily an accurate summary of the amount of the employe's time actually spent on grounds labor.) Five hospitals have one full-time and one part-time grounds keeper; eight hospitals have one full-time worker only, and ten hospitals have an employe who spends something less than his full time cutting grass, trimming shrubs and tending flowers.

Since the hospital site in all cases is within or adjacent to the city limits, the surrounding territory, as one would assume, is partially or wholly built up. In this group of hospitals, the area is described as partially improved in ten cases and as completely built up in thirteen cases. Overwhelmingly, these hospitals are located in residential neighborhoods. Fifteen of the respondent administrators described the hospital neighborhood as wholly residential; in the remaining seven cases in which replies on this point were received, the neighborhood was described as mixed, with some industrial or commercial building, as well as residences.

PROTECTED SITES

Of the five hospital sites that are not protected against the intrusion of undesirable buildings by zoning ordinances, three are in locations already diluted by commercial or industrial improvements. One hospital not protected by zoning laws volunteered the information that no such protection was needed, inasmuch as the hospital owned enough of the surrounding land to guard against the possibility of having undesirable neighbors.

In another case, a unique hospital site affords the same protection. "We are located on a small peninsula," this administrator wrote, "and the hospital owns practically the whole peninsula —12 acres altogether. The small strip of land back of the hospital on the peninsula is residential in character."

In conclusion, each of these administrators was asked whether or not the administrator or hospital trustees take part or have any interest in city planning. In fifteen cases the answer was affirmative, and the remaining eight answers were negative.

PEOPLE IN PICTURES

Faculty and students of the Colby College Extension Course in Hospital Administration, sponsored by the Maine Hospital Association. Front row, left to right: Dr. F. T. Hill, Dr. John Gorrell, Dr. Joseph C. Doane, Raymond P. Sloan, Faye Crabbe, Paul Spencer, Pearl R. Fisher, Arthur Seepe. Second row: Mrs. Etta Dodge, Mrs. Mary Morris, Marion Lamy, Louise Laney, Lois Bliss, LaVerne Riach, Dorothy Folta. Third row: Sister Mary Merci, Sister Annunciata, Edith Waddell, Hope Hawkes, Ida F. Buck. Fourth row: Sister Elizabeth, Sister Reviré, Mrs. Edith Masterman, Esther Willey, Evelyn Chamberlin. Fifth row: Sister Hortense, Sister Blanche, John J. Haughton, Charles Capron, Frank Curran.

Earl and Countess Mountbatten visit the booth of the Ontario Blue Cross Plan on the opening day of the Canadian National Exhibition, held in Toronto.

ABOVE:

Hospital accountants attending the I.B.M. Institute on Hospital Financial Control. Front row, left to right: E. C. Schroedel, H. M. Yerger, F. M. Hernan, L. M. Wright, Sister Ruth Anne, Sister Mary Gerald, F. T. Muncie, W. A. Harris, Sister Mary Juliana, Sister Mary Elegius, B. R. Judson, A. M. Teppe, E. M. Huelskoetter, W. C. Davison. Second row: E. R. Greenhood, J. D. Hosie, C. F. Graf, W. F. Follmer, G. K. McIllwraith, G. H. Gaddis, F. E. Oliver, R. H. Reeves, C. F. Mehler, J. K. Owen, A. R. Cumming, D. D. Colcock. Third row: L. R. Mobley, W. Dick, R. H. Hollerorth, G. H. Long Jr., C. F. Warfield, K. Benjamin, G. H. Rice, C. G. Puterbaugh, G. D. Delaney, A. L. McElmurry, E. H. Boruff, A. D. Lautzenheiser. Fourth row: W. J. McNamara, L. W. Foss, E. W. Jones, E. J. Logan, C. H. Clifford, W. F. Voboril, D. H. Spanier, F. A. Moffatt, H. O. Humbert, F. H. Bottger, J. E. Kalsh, R. G. Whitton, P. B. Shanks, W. P. Walther Jr.

The first nursing class to be graduated at St. Monic's Hospital, Phoenix, Ariz., included five Negroes, two Indians, one Japanese, three Latin Americans. The other four were Anglo-Americans.

It's easier to get graduate nurses when you can provide a brand new

NURSES' HOME

MELVIN H. DUNN

Assistant Superintendent, St. Luke's Hospital
Kansas City, Mo.

THE nurses' home of St. Luke's Hospital, Kansas City, Mo., is a four-story brick structure located on the south section of the hospital property. It is pleasantly situated in an exclusive residential section known as the Plaza District. The rear of this building is near a short street on which there is very little traffic.

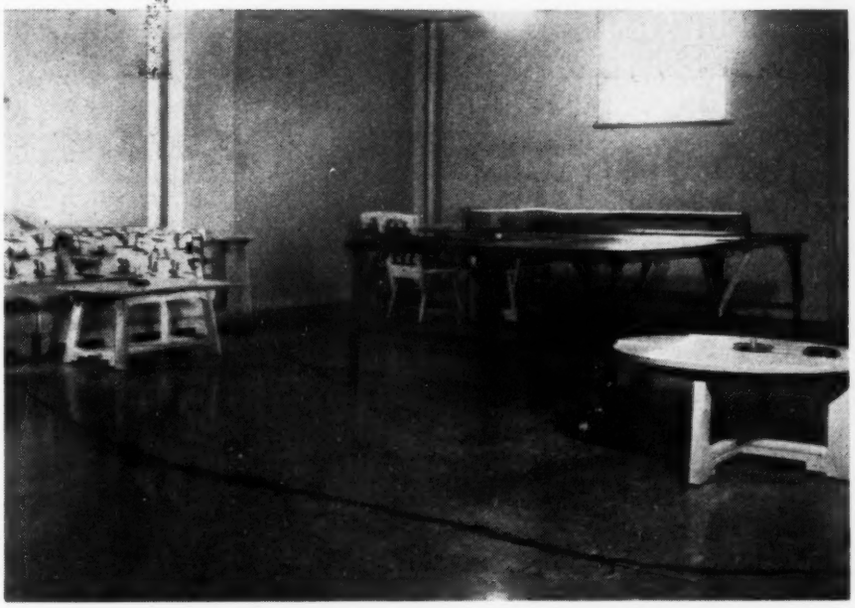
The entrance that is most used is at the side of the building. A wide, well lighted cement walk leads from this side entrance directly to the main dining room of the hospital.

On the ground floor just inside the entrance are located two offices used by the instructors. The students' laboratory, nursing arts room and recreation room are also on this floor.

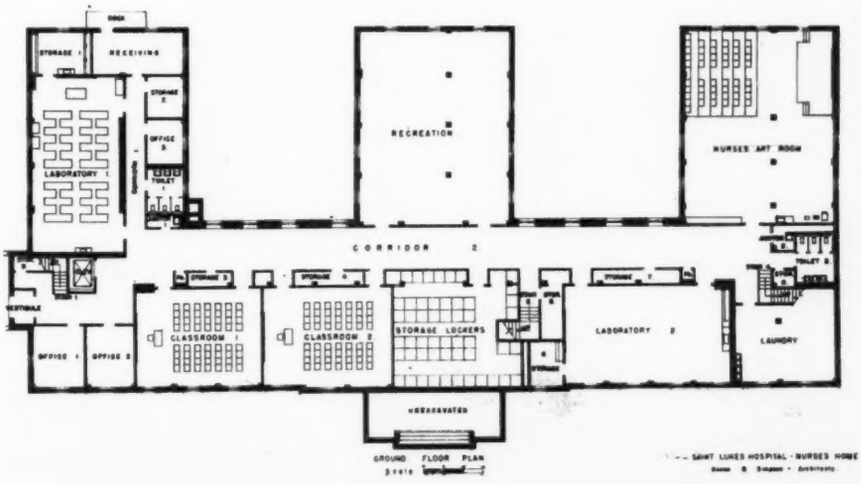
One of the most popular places in our nurses' home is the recreation room which contains a ping-pong table, lounge chairs, soft drink machine and card tables.

In the nursing arts room the chairs are on an elevated cement floor, making the demonstrations easily visible to each student.

The laundry is large and is equipped with two automatic washing machines.



The ground floor recreation room has added considerably to the morale of student nurses. In this atmosphere of play, they feel less restricted. Classrooms, laboratories and laundry take up the other areas on this floor.



CONSTRUCTION DETAILS

WALLS: Exterior, brick with cinder block backing; interior, plaster.

ROOF: Reinforced concrete with tar paper and gravel as a covering.

CEILING: Suspended, with metal lath and plaster. Acoustical treatment used in the nurses' home proper.

LAUNDRY ROOMS: Walls, glazed tile; floors, tile.

TOILET AND SHOWER BATH: Gray marble interior walls with tile flooring.

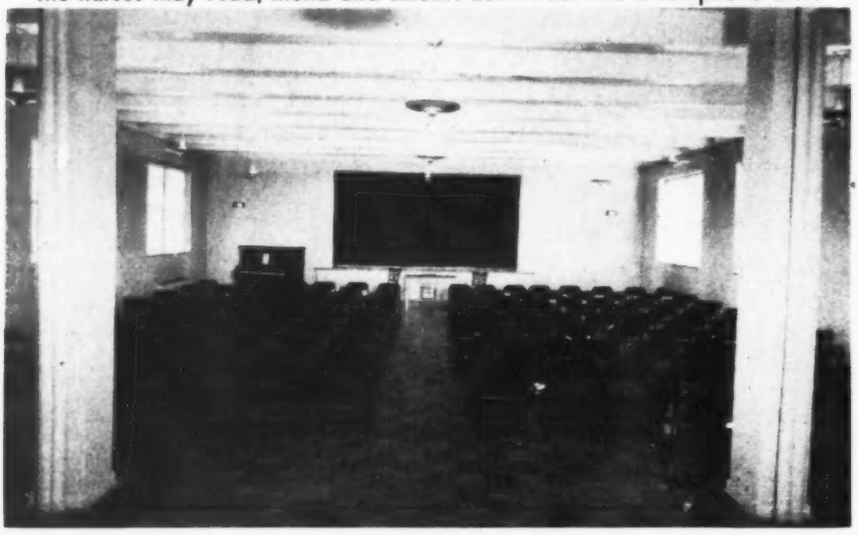
FLOORS IN GENERAL: Reinforced concrete with asphalt tile; auditorium—oak (block type); lobby and auditorium foyer—terrazzo.

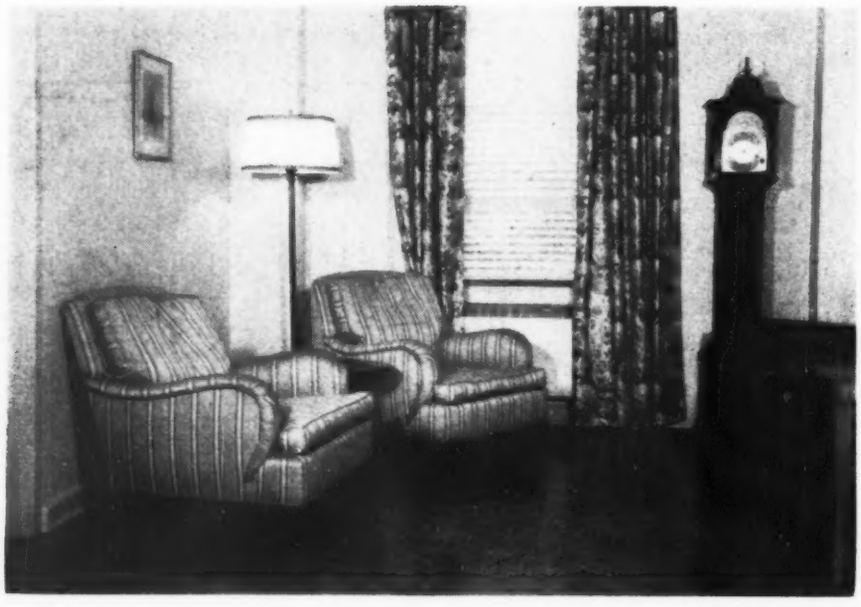
STAIRWAYS: Steel with cement treads.

WINDOWS: Window stools are of marble; combination metal jam and trim.

CONSTRUCTION AND COSTS: This building was erected with the assistance of federal funds with the hospital receiving 40 per cent of its cost from the government under the Lanham Act. The building was designed by Keene and Simpson, architects, of Kansas City, Mo., and the construction was done by Swenson's Construction Company of Kansas City. The cost of the building, additional furniture and the architectural fees approximated $470,000.

The auditorium with its stage and two dressing rooms is a central feature of the first floor plan. it is used for theatricals, lectures and lantern slide displays. The living room is on this floor, with two date rooms adjacent. There is a small lounge (bottom of page) on the bedroom floors where the nurses may read, mend and smoke. Each floor has a telephone also.





The cost to the student is 10 cents for 10 pounds of laundry done. In addition to the large laundry room in the basement, six small laundry rooms are provided.

There are an automatic elevator and three stairways leading from the ground floor to the first floor.

A storage locker is provided for each nurse. It contains ample space for a small trunk, two suitcases, and a reasonable amount of space for books not being used. These lockers are constructed of chicken wire around a wooden frame. Each nurse possesses her own key.

The main entrance has two revolving doors and two glass doors on each side. The wide cement walk leads to the entrance and also to a wing spread leading to the main hospital and to the side street.

To the right of the entrance door on the main floor is the office which is enclosed in glass. The metal mailboxes, one for each girl, are in a small well lighted room. Mail is distributed to the boxes in the office side of this room.

Just off the main office is the matron's room with a private bath and telephone. She is immediately available when necessary.

The students' library, a men's lounge, living room, date rooms, auditorium and a small kitchen are also located on the first floor.

The auditorium, which has a stage and two dressing rooms, is used for entertainment purposes. Lectures are held here and large and small groups may gather to view slides shown on screens. This room is equipped with venetian blinds and also dark curtains for daytime use. The doors to the auditorium are of the glass window type. On either side is a small table on which flowers from the garden are kept.

The large living room is furnished with four settees, eight overstuffed chairs, radio, floor lamps and piano.

The small kitchen was provided for the convenience of nurses who wish to sleep late. They are privileged to get their own breakfast. This kitchen has a gas stove, refrigerator and a good supply of dishes. The breakfast room is adjacent to the kitchen. We are proud to report that the privilege of using the kitchen is not abused.

Adjacent to the main lobby are two date rooms. In each date room we have two-section settees, two lounges of different colors, and floor lamps.

On each of the floors about midway is a conveniently located space in which there are a two-section settee and four chairs. These are used by the nurses who want to read, mend clothing or smoke. A telephone is on each floor for the convenience of the nurses. This has proved highly desirable as there are many times when the nurses do not care to dress and go to the first floor to receive their calls.

A sun deck is provided and walled off. This deck is elevated to ensure the privacy of occupants. Just off the sun deck is an alcove where porch furniture is used for resting after sunbathing.

Each bedroom has one or two outside windows. These rooms are furnished with twin beds, floor lamps, writing desk with compartments on both sides for students' books, and easy chairs.

The director of nurses has a bedroom, living room, a large dressing room, and private bath.

A sufficient number of showers are provided for the nurses and, in addition, there are baths on each floor.

A zone controlled automatic gas furnace is used to heat this building and a bell installed in the main office rings in case the furnace fails to operate properly. An auxiliary tank is available for oil.

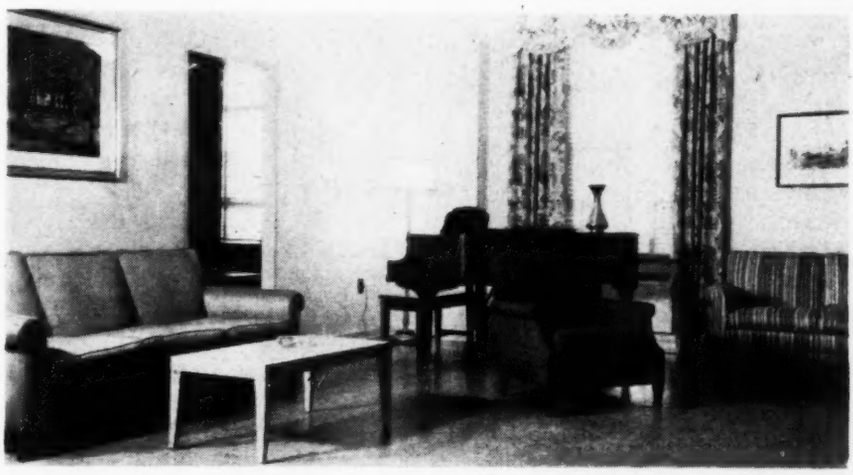
A sufficient amount of storage space has been provided for linens, housekeeping equipment and luggage.

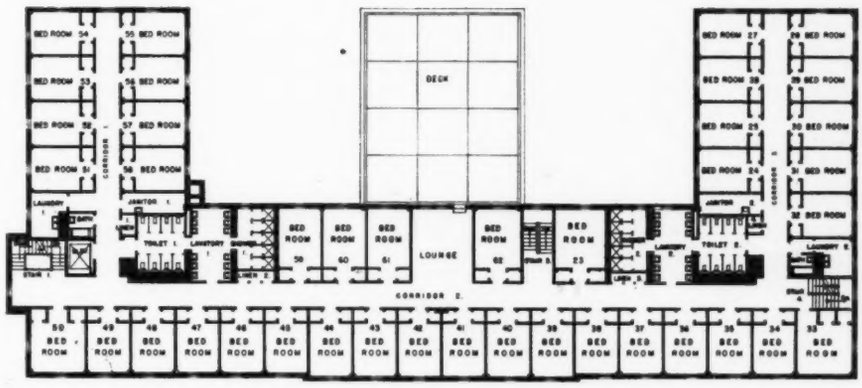
The building's maintenance staff consists of a janitor who does all the wet mopping and window washing and three women who do maid work. These women relieve the matron on watch and answer telephones as often as necessary.

Anyone who has been around hospitals for some time can well imagine what a real home atmosphere has done for the morale of the student nurses who perhaps for the first time in their lives have been separated from their families. The recreation facilities have also helped to bring about this favorable result and the student nurses do not feel as restricted as they once did.

Graduate nurses, as everyone knows, have been difficult to get. By offering graduates living quarters in the new nurses' residence, we have been able to attract more of them. In our section of Kansas City, rent is high and housing is limited. Without the nurses' home, we should be in an unenviable position in this respect.

One corner of the large living room on the first floor, along with the second floor plan, and a view of a bedroom with its two decker bed, study desk and lounge chair. The third floor plan is similar. A roof deck proves popular in summertime. It includes a sun deck, where privacy is assured, and an alcove where the girls may rest after sunbathing.





SECOND FLOOR PLAN

ABOUT PEOPLE

Administrators


Dr. J. R. Miller

Dr. James Roscoe Miller, 43, dean of the medical school of Northwestern University, has been elected to succeed **Franklyn Bliss Snyder** as president of the university when the latter retires next summer.

One of the youngest men ever elected to head the university, Dr. Miller received his medical degree from Northwestern in 1930 and a master of science degree a year later. He was a commander in the medical corps of the navy, in charge of the section on internal medicine of the bureau of medicine and surgery. He also participated in the development of base hospitals in the Pacific theater. He is president of the Chicago Medical Society, president-elect of the Association of American Medical Colleges, and is a trustee of Wesley Memorial, Passavant Memorial, and Evanston hospitals.

Dr. Miller has been dean of the medical school for seven years; he was assistant dean from 1933 until 1941.

Dr. David Salkin has resigned as superintendent of Hopemont Sanitarium, Hopemont, W.Va., to become chief of professional services at Veterans Administration Hospital, San Fernando, Calif. **Dr. A. L. Starkey,** formerly assistant superintendent, is now acting superintendent at Hopemont.

Sister Mary Gervase has returned to Hamilton, Ohio, as Superior of Mercy Hospital and the Mercy Hospital School of Nursing. Sister Gervase was director of the nursing school for twenty-four years and served as administrator of the hospital for six years prior to the appointment of **Sister Mary Benignus.**

Dr. Roger B. Nelson, who joined the administrative staff of the New York Hospital as an executive assistant to the director in February 1947, has been appointed assistant director of the hospital. He retains his title of director of the outpatient department along with that of assistant director.

Vernon C. Stutzman, following the completion of an administrative residency, assumed his duties as assistant director of Jewish Hospital of Brooklyn. Mr. Stutzman is a graduate of the course in hospital administration at Columbia University.

O. H. Overland, administrator of Grand Forks Deaconess Hospital, Grand Forks, N.D., for thirteen years, is now manager of St. Luke's General Hospital, Bellingham, Wash.

Mrs. Helen C. Anthony is the new administrator of Clover Hill Hospital, Inc., Lawrence, Mass., having assumed that position October 1.

John F. Berry has been appointed assistant superintendent of the Springfield Hospital, Springfield, Mass. Mr. Berry received his master's degree in hospital administration from Columbia University and completed his year's internship at Springfield Hospital in June.

William H. Hoobler has succeeded the late **H. W. Popper** as administrator of Roanoke Hospital, Roanoke, Va. Mr. Hoobler was formerly assistant superintendent of Youngstown Hospital, Youngstown, Ohio.

Eugene V. A. Adams is the new director of Chester County Hospital, West Chester, Pa., having assumed his responsibilities there on September 16. He was formerly with the Pennsylvania Economy League.

Martha C. Lockman has assumed the position of administrator of Amsterdam Hospital, Amsterdam, N.Y. Miss Lockman was formerly superintendent at St. Barnabas Hospital, Minneapolis. She is a graduate of Goucher College and the University of Chicago's course in hospital administration.



Left: Martha C. Lockman, Amsterdam Hospital, Amsterdam, N.Y. Right: Louis S. Reed, chief, office of special services, Hospital Facilities Division of the U.S.P.H.S.


Dr. Lendon Snedeker

Dr. Lendon Snedeker, associated with Children's Hospital, Boston, as assistant physician since 1934, has been appointed assistant administrator of Children's Medical Center. Dr. Snedeker is instructor in pediatrics at Harvard Medical School and has been visiting pediatrician to the obstetrical service of the Massachusetts Memorial Hospitals since July 1947.

Sister Celestine, administrator of Hotel Dieu, New Orleans, has been appointed a member of the committee for the administration of the accrediting program of the National League of Nursing Education. Sister Celestine was director of the Hotel Dieu School of Nursing for eighteen years prior to her appointment as administrator of the hospital two years ago.

Burton M. Battle, superintendent of New Orleans Hospital and Dispensary for Women and Children, New Orleans, since 1941, has resigned his position effective November 1.

Department Heads

Dr. Shelby G. Gamble has been appointed head of the department of physical medicine at Cleveland Clinic. Dr. Gamble has been assistant professor in the department of medicine at Ohio State University College of Medicine for the last three years. During the same period he has been director of the departments of physical medicine at both University and Children's hospitals in Columbus.

Edna S. Newman has been appointed director of nursing service and the school of nursing at Wesley Memorial Hospital, Chicago, succeeding **Harriet Smith.** Miss Newman has been director of nursing service at Cook County Hospital, Chicago, for the last eleven years and served earlier as director of the school of nursing at St. Luke's Hospital, Cleveland. She has been an assistant professor of nursing education at the University

(*Continued on Page* 202.)

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

STOP DODGING YOUR DUTY TOWARD THE MENTALLY ILL

THOMAS A. C. RENNIE, M.D.

Associate Professor of Psychiatry
Cornell University Medical College

IT WAS in 1771 that the New York Hospital, one of the earliest in the country, was chartered by the Crown. This charter provided that the hospital accept patients suffering from mental disorders because their treatment was considered as important as that of the medical and surgical patients.

It was not until 1808 that the psychiatrically disabled were segregated in a separate building, and not until 1821 that the psychiatric division was moved to the country, the present Westchester Division. Today we are back where we started, with a consideration of the general hospital and its responsibility to the mentally sick.

Public and private psychiatric hospitals are today crowded to the front doors, and there is no relief in sight. A rising flood of neurotic and psychotic patients is being educated to seek help which is not available. Hundreds of thousands of emotionally disturbed people go to doctors and hospitals for treatment which has little bearing on their real condition. In urban centers, particularly, patients are shunted from one to another specialty clinic or ward, where most of their examinations are impersonal and curiously unrelated to the anxious persons whose bodies are so meticulously searched.

A mass of detached facts accrues; fact histories evolve, and baffled and confused patients go home clutching a label of a diagnosis, little more edified than when they came. The miracle of medical science and efficiency comes more and more effectively to play upon those patients, curing many of somatic disease, but failing in the main to meet the needs of the emotionally and mentally handicapped, who are all too often made worse by the process. Where will those emotionally and mentally disturbed patients find help? Out of some 4500 general hospitals in the country, only 127 accept or provide for the emotionally handicapped.

GENERAL HOSPITALS MUST ACT

It is my thesis that the general hospital is in a uniquely favorable situation to meet and resolve the mental health problems of the members of the community which it serves, and that it must assume this function. With few exceptions the general hospital has evaded this responsibility, and no general hospital has as yet given evidence of facing and assuming its total responsibility. This is one of the major obligations that lies ahead.

Psychiatry and medicine are at last becoming united, with the abolition of the concept that psychiatry is a remote specialty and with growing awareness on the part of many that the combined psychiatric-medical approach is the only tenable one for the full understanding of all medical and surgical issues. While the point of view has grown and strengthened, it remains as yet to be implemented into action.

Slowly the concept gains acceptance that the emotional factor is of prime significance in every patient, whether it be problems of general medical and surgical concern, psychosomatic states, preoperative and postoperative anxieties, accident proneness, adjustment to motherhood and fatherhood, the care of the sick child, or the more easily identifiable psychiatric disorders of depression, postoperative and postpartum psychoses, delirium, excitements, chronic alcoholism, or central nervous system damage.

These are all conditions which can well be managed in the general hospital without recourse to psychiatric hospitalization, and where there are few or poor specialty hospitals available they become imperatively the responsibility of the general hospital. This calls for increasing understanding of their nature, skill in their treatment, and an assumption of responsibility for their management.

It matters little whether at first this point of view is implemented through the use of psychiatric consultants, the development of psychosomatic units, or the education of general physicians. For the time being, it must mean the acceptance of the psychiatrist as an integral member of the hospital team, working side by side with internists and surgeons in daily practice and supplemented by the growing utilization of the psychologist and social worker as intrinsic members of the therapeutic team. Ultimately, it must mean a new kind of medical practice.

The next years must therefore be devoted to a general educational program aimed not alone, as now, at resident and attending staff, but also at all personnel of a general hospital, from nurse and attendant to secretary. It must extend also to patients' families and their friends, to all the agencies—social, recreational and otherwise—that exist in a community and which can be utilized by medicine in its search for total health for all.

Such a development envisions an increasingly close relationship between the hospital and community. It is from the community that sick people come, and to the community that sick people return. There can be no good medicine that does not recognize the environmental, social and economic forces that bear upon ill health. Unless the community is considered as part of the hospital, and *vice versa*, these forces go unrecognized and unmanaged. The treatment of every patient reflects not only upon himself but also upon his family, and hence ultimately influences the attitudes of

Presented to the National Health Assembly, Washington, D.C., May 1948.

Aerosol Inhalation Therapy

GREATLY SIMPLIFIED WITH

SOLUBLE TABLETS

CRYSTALLINE PENICILLIN G POTASSIUM

Each foil wrapped tablet contains 50,000 units, the usual single dose.

The tablet is simply dropped into the nebulizer,

10 to 15 minims of water or saline solution are added with a dropper,

and the prescribed dose is ready for administration.

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the entire community. Here, then, is not only a golden opportunity for education in mental health matters, but also a unique opportunity for good public relations to result in public support and concern about the community hospital.

Further, preventive medicine requires the searching out of sick people, the eradication of individual and social foci of illness, and the increasing preparation of the community through education for the assumption of its total rôle in maintaining health and preventing ill health. The general hospital which performs its function well carries dignity, prestige and authority for all health matters. It can no longer exclude mental health matters. It can no longer ignore the need to find some substitute for the vanishing patient-physician relationship.

It is possible to develop emotional attitudes toward a clinic or hospital as a whole and to utilize this for therapeutic good. It can only exist when a spirit of group cohesiveness exists; when the total staff functions as a team, and when the patients share in the team spirit. This team spirit is as important for the secretary or registrar as for the chief of surgery. It cannot exist when the specialist in emotional and mental factors is relegated to a special unit or wing, and his patient is looked upon as different from the stream of other patients. Where integration and team spirit exist, something of the lost warmth of the individual patient-physician relationship can be restored.

DAILY CROP OF DISORDERS

Even a cursory glance at the kind of problems met in everyday practice in a general hospital will reveal some of the opportunities to be met and resolved. In medicine, there are the endless daily problems of differential diagnosis; the determination and management of the emotional factor in pain, headache, vomiting, convalescence; reaction to drugs; suicidal attempts; mental effects accompanying toxic and infectious states; depressive and panic reactions; insomnia; belligerent, uncooperative, suspicious, antagonistic patients; anxious relatives; the whole range of psychosomatic disorders, and the vastly significant area of the interpersonal relationship between doctor and patient, and nurse and patient.

On surgical services, there are the multiple problems associated with anxiety, hypochondriasis, hysteria, "surgical addiction," drug addiction, delirium, alcoholism, mental deficiency, epilepsy, psychic invalidism, evaluation of pain, accident proneness, the growing utilization of surgical procedures in hypertension, cardiac spasm, ulcer, ulcerative colitis, hyperthyroidism, lobotomy and leukotomy.

There is need for preventive work in preoperative attention to anxiety, sleeplessness, attitudes toward operation, fear of mutilation and of sexual change, anticipation of postoperative handicap, postoperative delirium tremens, the limitation of function, and the disruption of lifetime adjustment by surgical procedures, particularly in elderly patients. The need for psychotherapeutic orientation is obvious.

In obstetrics, the problems are almost more numerous: attitude toward pregnancy itself and its effect upon the birth process; preparation of the mother for delivery and motherhood; abolition of fears and misconceptions; reduction of pain during labor; postpartum psychoses; problems of sexual maladjustment; attention to the emotional relationship of mother and child; breast-feeding; experiments in "rooming-in," and problems of vomiting. The management of all of these reactions requires real insight on the part of obstetrician, pediatrician and, particularly, nursing personnel.

In pediatrics, there is need for further development of well baby clinics, attention to the emotional needs of the infant and child, education of parents, wiser management of the hospitalization of small children, with its separation from home, specific metabolic and endocrine disorders, and attention to the vast range of family, social and environmental factors that lead to healthy child growth.

Here, then, are unique opportunities for preventive and prophylactic work. It is in the general hospital that incipient emotional disorders are most likely to appear. Early attention to those has vast preventive possibilities for the future health of the individual.

One might multiply endlessly the varieties of problems that are today commonly recognized in the practice of medicine in a general hospital. They even include those problems of industrial psychiatry which have to do with effective working relations among professional and nonprofessional staff members. The task may seem insurmountable, and yet significant advances have already been achieved in bringing about a heightened awareness of these human and personal factors in disease, the need for their recognition, the development of skills in their management, particularly by internists and pediatricians, the rapidly accumulating body of knowledge concerning convalescence and rehabilitation, and the development of outpatient and follow-up clinics.

Much more needs to be developed in the wider dissemination of this knowledge, in the better preparation of nurses for their significant rôle in interpersonal relations, in the making of such principles an integral part of the practice of all medicine. The trend toward group practice in smaller communities shows a healthy determination to include the psychiatrist for his contribution to all such problems.

EXPERIMENTS IN GROUP THERAPY

Many of these problems can only be met by individual psychotherapy. Many more of them, particularly those relating to the management of psychoneurotic and psychosomatic patients, the education of parents, the preparation for childbirth, could well be met by group therapy methods. Already some such experiments are under way, particularly in the form of self-study groups for parents, organized around well baby clinics. The whole job, however, requires that the general hospital staff go out more aggressively into the community.

There is need for a coordinated attack which will utilize every resource for recreational, social and vocational outlets, the use of home visits, the assignment of medical students to the study of families in their homes. Here is a tremendous task of interpretation which can only come about by increasingly close liaison between the general hospital and community members and agencies.

The function of a general hospital is not only to cure disease. It is to contribute to the general well-being of all members of the community toward the end of keeping people well. This requires a social concept that has been too long absent in medicine. It should come from the general hospital, not the psychiatric hospital or outpatient service. It will come when the hospital finally realizes that its function is to treat people, and not diseases.

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MEDICINE AND PHARMACY

THEY DESERVE GOOD TEACHERS

But medical students, interns and residents get few enough of them

S. O. WAIFE, M.D.
Assistant Director in Charge of Medical Education
Philadelphia General Hospital

IT IS a curious anomaly in educational circles that medicine, a profession with so many schools, students, practitioners, laboratories and publications, should be so devoid of *trained teachers.*

This is the most serious deficit among hospital staffs[1] and is reflected in part in the great variation in the training of physicians in the various schools. The schools with the wider reputations (a phenomenon closely related to the larger endowment) can attract and employ the few outstanding teacher scientists, the leaders of medicine, to the aggrandizement of their schools and to the poverty of the others.

It is strange that little formal effort has ever been made to qualify a sufficient number of physicians in the art of teaching. A man might be a teacher of English in a high school or a teacher of history in college. Teaching is his profession; history, the subject. But not in medicine. Here one is a surgeon who also teaches, or a biochemist, an investigator primarily, and a teacher of biochemistry second.

Few, if any, medical schools and teaching hospitals have on their staffs men who are essentially interested in teaching and who have some training in pedagogy, and to whom clinical practice or laboratory experiments are corroborative but still not their primary interest.

Analysis of this strange situation will reveal several factors, chief among them the fact that because no such entity exists no encouragement or opportunity is given to the few who might select such a field. Thus, without a chance for the birth of this profession to occur, only spontaneous generation may yield that product.

SALARIES TOO LOW

Another matter, forming an arc of a vicious circle, relates to the medical schools, which not only greatly underpay their staffs[2,3] but often put a premium on research work, qualitative, of course, but occasionally quantitative. This means that only those who are financially independent can stay long enough in the academic field to make their mark and even if so blessed they must continue to produce even if it is a grain of sand on the beach of medical knowledge. It would be unthinkable for a man to be hired at a self-respecting salary for the sole purpose of teaching, or lecturing, or making ward rounds.

The trend toward full-time teachers, the stimulus of which came with the founding of the Johns Hopkins Medical School, is an indication of the direction of the wind. But even this movement has not produced its maximal results. It has usually selected as its full-time physicians men who have produced outstanding work, in addition to being either good teachers or executives and administrators. The pure teacher, admittedly less valuable than the excellent teacher-investigator-executive, is, however, ignored. No career in a full-time strictly teaching profession exists for him.

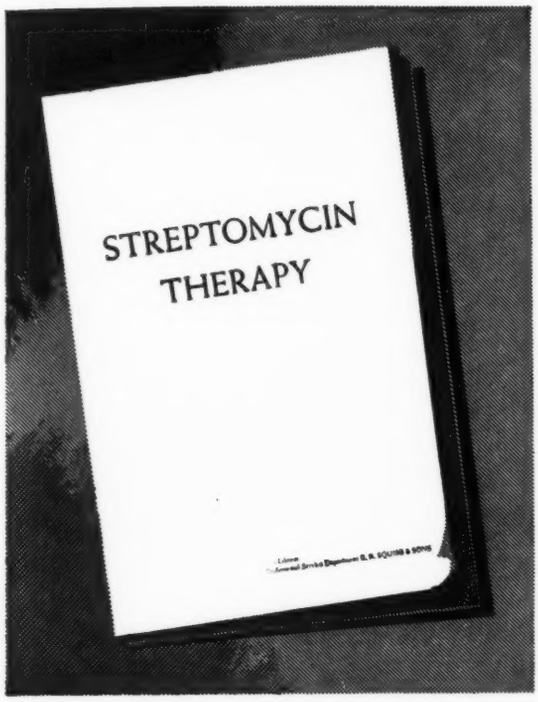
Even those who do carry the teaching burden—and it is strange to put "teaching" and "burden" always next to each other—even they are never trained in the elements of pedagogy. With education blossoming in hundreds of channels, teachers colleges and state normal schools, for kindergarten teachers to college professors, still no man who teaches our future doctors ever is told anything about elementary principles of visual and sensory technics, lesson planning, motivation, learning curves and correlations of teaching methods.

Therefore, the instruction of our interns and residents, like that of our medical students, has been left largely in the hands of teachers who lack an understanding of the principles of teaching, and who lack an understanding of how to ensure educational progression of their charges. This is because they are (1) untrained in teaching, (2) primarily practitioners or scientists, (3) not recognized as a professional entity entitled to academic and financial dignity.

It can be rightly argued, of course, that there is a tremendous amount of excellent teaching going on all the time throughout the country. This is carried on by hard working, relatively underpaid scientists in the so-called "preclinical" subjects and by a host of physicians and surgeons who are actively engaged in practice in the clinical field.

It can also be argued that only those actively concerned in research or in the daily bedside practice of medicine would make our finest teachers. And certainly no one would want an ivory-tower dreamer, out of contact with the prosaic realities of the laboratory or bedside, to teach new doctors who

[1]Internships and Residencies, New York Committee on the Study of Hospital Internships and Residencies. New York: Commonwealth Fund.
[2]Butler, A. M.: The Teaching Hospital's Service to the Public, N. Eng. J. Med. 236:497 (April 3) 1947.
[3]The Nation's Medical Research, v. 5; Science and Public Policy. J. R. Steelman ed., U.S. Gov't Print. Office, 1947.



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must face the aforementioned prosaic realities.

Teaching is an art. It requires a great interest in the subject matter, an ability to transmit information, an ability to evaluate the individual differences of the students. But more than that, teaching is the spreading of enthusiasm. It is that intangible facility for enlivening any subject, or showing new puzzling features, for challenging the intellect and the spirit, for creating an epidemic of contagious fascination and effort.

Those who possess this art are uncommon, indeed. Therefore, all opportunities for its discovery and cultivation must be made available. If the ideal teacher is not also an original investigator or a successful practitioner, he should still be carefully guarded, for this talent is exceedingly rare.

When medicine realizes it has not provided for its own potentially highest improvement by stimulating a sect of professional teachers, it may correct this tremendous oversight with untold advantages to itself and to society as a whole.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

QUINIDINE

QUINIDINE is the dextro-isomer of quinine with which it occurs naturally in cinchona bark. Its physical, chemical and pharmacological properties are qualitatively similar to those of quinine. Like the latter it is a general protoplasmic poison. It owes all of its important pharmacological effects to this property, through which it inhibits certain enzyme systems.

As a cardiac depressant, quinidine was little known until 1918. In 1914 Wenckebach reported that quinine which was administered to a patient for its antimalarial effect also stopped the coincidental auricular fibrillation. Four years later Frey thoroughly investigated the efficacy of quinine, cinchonine and quinidine for the treatment of auricular fibrillation and found quinidine to be the most effective. Since that time quinidine has been employed extensively in the treatment of certain hyperdynamic cardiac arrhythmias in which a cardiac depressant is indicated. After thirty years it is still the drug of choice for such conditions.

Pharmacological Effects on the Heart

One of the most important pharmacological actions of quinidine on the heart is its ability to prolong the refractory period. Experimentally this prolongation has been shown to be from 50 to 100 per cent, which means that the period of excitability of cardiac muscle is proportionately reduced. This action applies equally well to both auricular and ventricular muscle and constitutes the basis for quinidine therapy in ventricular tachycardia whether it is of supraventricular, nodal or ventricular origin. Thus, quinidine is a general cardiac depressant and does not exhibit a selective effect on any part of the myocardium.

Quinidine may increase or decrease the amplitude of contraction of the heart. This depends upon both the previous heart rate and the size of the dose. In the rapidly beating heart, therapeutic doses of quinidine will increase the amplitude of contraction. This effect is purely secondary to its action to slow the heart rate, allowing a greater period of diastolic filling and, hence, a greater amplitude of contraction. However, larger doses of quinidine will definitely decrease the amplitude of contraction by a direct depressant effect which overbalances the response to greater diastolic filling.

The slowing effect of quinidine is due not only to its action in prolonging the refractory period and retarding impulse transmission but also to its ability to depress the rate of impulse formation at the sino-auricular node. This accounts for the excellent results obtained with quinidine in the treatment of sinus tachycardia.

The cardiac slowing effect of quinidine is not altered by atropine, indicating that such an effect is not mediated by any vagal action. In fact, there is evidence which shows that quinidine paralyzes vagal nerve terminations. In this way quinidine differs remarkably from digitalis which produces a part of its slowing effect by vagal nerve stimulation. Also, the slowing effect of digitalis is more selective, affecting especially the conduction system.

The electrocardiographic effects of quinidine are numerous and depend to some extent upon the dose. The P-R interval is prolonged, the duration of electrical systole is increased as evidenced by a prolonged QRS complex. The T-wave may be notched or inverted and there may be deviation of the S-T segment. Paradoxic tachycardia has been observed and even ventricular fibrillation has been reported, a surprising effect from a cardiac depressant such as quinidine.

The paradoxic tachycardia, though not frequent, is often seen when quinidine is employed in the treatment of auricular fibrillation. Here the drug occasionally acts to convert auricular fibrillation to auricular flutter, in which case the response of the ventricles is more rapid and more regular than is the case in auricular fibrillation. This effect on the ventricles can be prevented by the previous or simultaneous administration of digitalis which acts more selectively in depressing auricular-ventricular conduction.

Absorption and Excretion

Quinidine is rapidly absorbed and rather rapidly excreted when administered orally. Sagall and co-workers have demonstrated that following an oral dose the maximal concentration of the drug in myocardial tissue of dogs occurs within half an hour to an hour, and after from four to seven hours none of the drug can be found in the heart. It occurs in the urine within two to three hours and only traces can be detected after from twelve to twenty-four hours. If it is administered more rapidly than intervals of four hours quinidine exhibits a cumulative effect; however, there is no evidence that the drug is stored in the body. The magnitude of response is proportional to the dose.

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Therapeutic Uses of Quinidine

Quinidine has been used effectively in the treatment of various cardiac arrhythmias, especially the paroxysmal types. The most outstanding therapeutic effects of the drug have been observed in the following types of cardiac disturbances:

1. *Auricular Fibrillation.* Quinidine is quite effective in converting auricular fibrillation to sinus rhythm. This is especially true for paroxysmal auricular fibrillation. More recently it has been observed that quinidine is of great value in the treatment of persistent auricular fibrillation in which there is minimal cardiac damage and little cardiac enlargement and which is under six months' duration. It may be employed following thyroidectomy to convert persistent auricular fibrillation to sinus rhythm. It may be used to stop auricular fibrillation in patients with recent myocardial infarction. In such cases the smallest effective dose should be employed because a large or toxic dose may further depress the already depressed heart.

The previous or simultaneous use of digitalis should be considered when quinidine is employed in the treatment of auricular fibrillation. The rationale for digitalis in this condition is based upon the paradoxical tachycardia which sometimes develops when quinidine is used to convert auricular fibrillation to sinus rhythm. If auricular flutter should develop, rather than sinus rhythm, digitalis will sufficiently depress the conduction system to prevent the usual ventricular tachycardia.

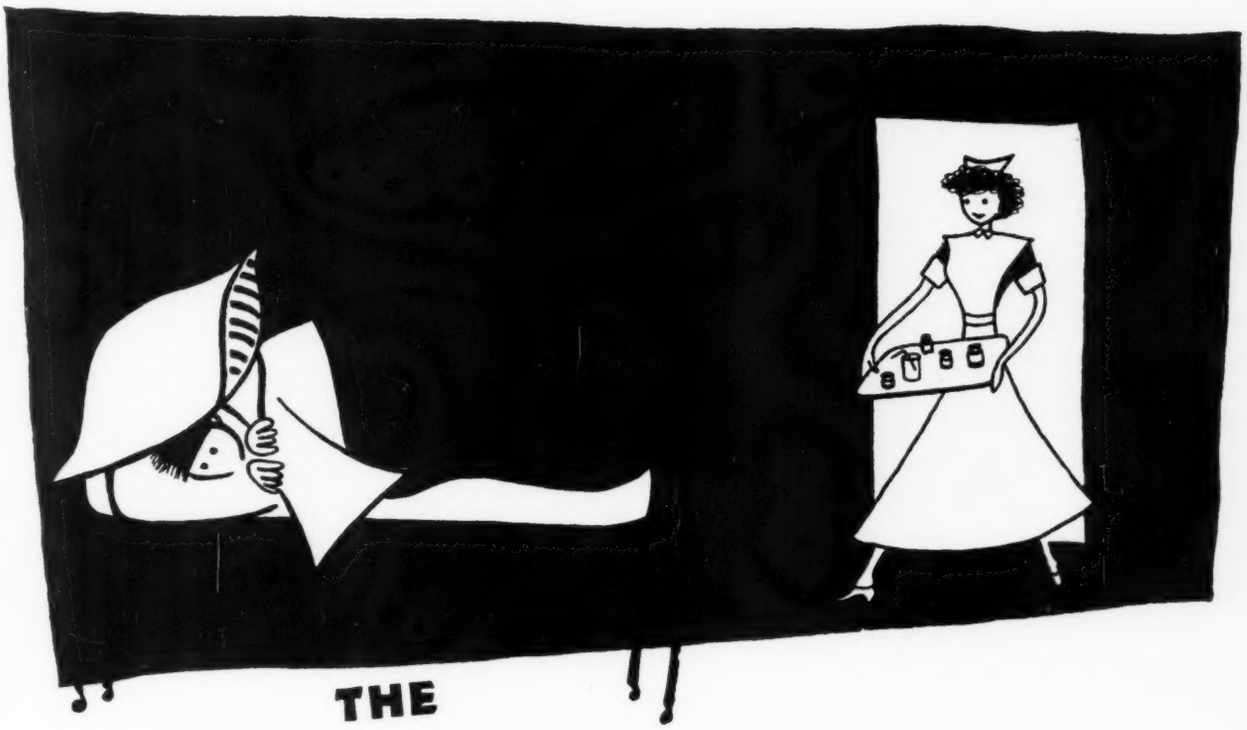
Quinidine has been found to be effective in converting from 50 to 75 per cent of all cases of auricular fibrillation to sinus rhythm. In order to abolish the arrhythmia, the effects of the drug in prolonging the refractory period must be proportionately greater than its effects in slowing conduction, otherwise the arrhythmia will become fixed.

2. *Auricular Flutter.* While this condition can be converted to sinus rhythm with quinidine, the drug is far less effective than it is in the case of auricular fibrillation. Digitalis is the drug of choice in the treatment of auricular flutter. After digitalis has succeeded in converting auricular flutter to auricular fibrillation, quinidine may be employed, although it is not absolutely essential, to hasten sinus rhythm. Digitalis has the added advantage of rapidly depressing impulse conduction and in this way slowing the heart rate in auricular flutter to 60 or 70 beats per minute.

3. *Paroxysmal Ventricular Tachycardia* can be stopped and prevented with appropriate quinidine therapy. This is of special importance when the tachycardia is of sufficient magnitude seriously to diminish cardiac output. Quinidine has been used with great success in the treatment of tachycardia complicated by organic heart disease.

4. *Premature Systoles* can be controlled with quinidine but it should be employed only if the premature systoles cause distressing symptoms. It may be employed when digitalis causes premature systoles. Since such an arrhythmia is an important sign of digitalis overdosage the digitalis should be stopped or the dose should be reduced. Quinidine has been used prophylactically in mitral stenosis with associated premature systoles to prevent the onset of the more serious auricular fibrillation.

Premature systoles in coronary disease frequently precede the onset of paroxysmal ventricular tachycardia,



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ventricular fibrillation and death. This chain of arrhythmias can be checked or prevented by the administration of quinidine. Some cardiologists employ quinidine routinely in small doses in all cases of recent myocardial infarction to prevent just such an outcome. It has been observed clinically that the incidence of angina pectoris and heart failure is effectively lowered by the prophylactic use of quinidine.

Contraindications

Most of the contraindications to quinidine are relative. Heart disease of long duration, congestive heart failure with marked cardiac enlargement, toxic myocarditis, as may be seen in acute infections and in subacute bacterial endocarditis, may be aggravated by quinidine.

In the absence of premature systoles intraventricular block is a contraindication to quinidine therapy because such a block is already a sign of cardiac depression. In longstanding auricular fibrillation, quinidine is said to be contraindicated because such a condition predisposes to embolic phenomena which may be precipitated by quinidine. It should not be employed in those who show idiosyncrasy to the drug or in those who readily develop cinchonism.

Toxic Effects

Although quinidine constitutes an effective and valuable part of the physician's therapeutic armamentarium, it can be a dangerous drug when employed indiscriminately and without due consideration of its toxic potentialities. Toxic symptoms may be due either to idiosyncrasy or to cinchonism. While idiosyncrasy is rare it may be well to administer a test dose to each candidate for quinidine therapy.

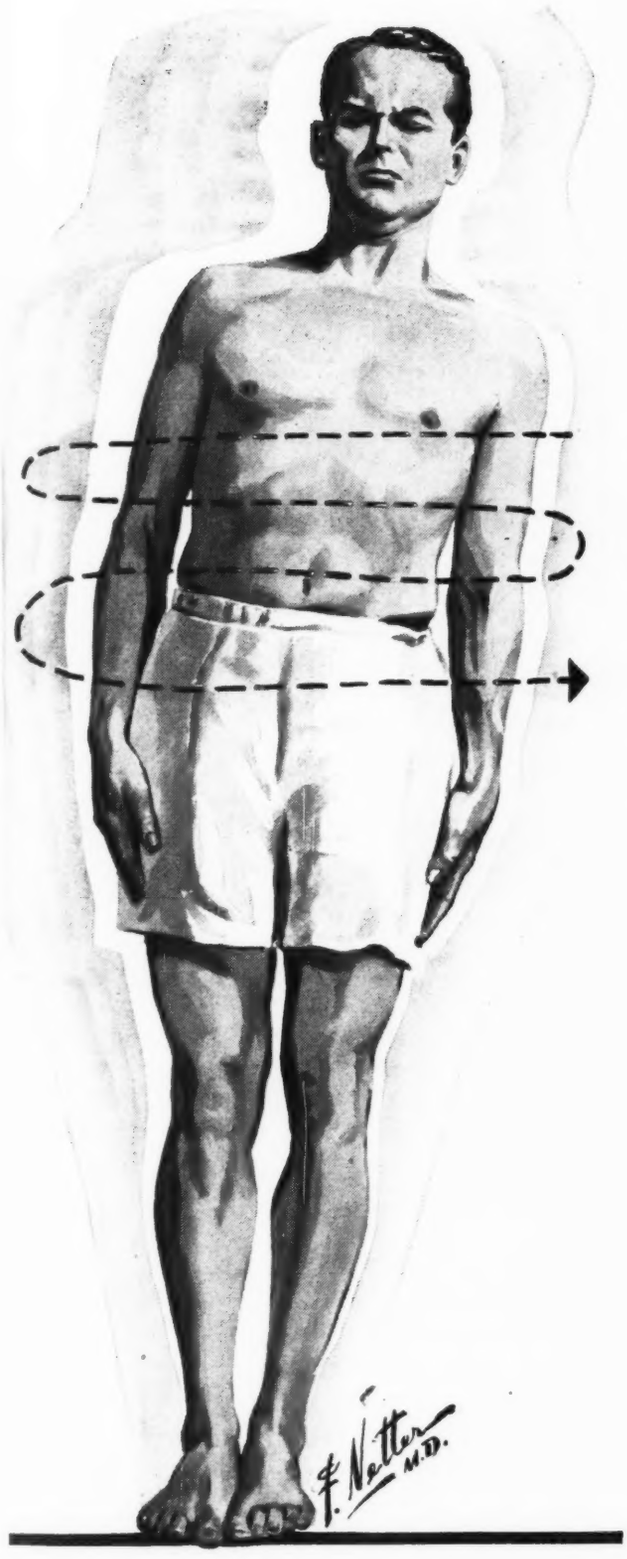
Cinchonism may develop during the course of the drug. It is manifested by headache, tinnitus, visual disturbances, fever, fainting, anorexia, nausea and vomiting, and diarrhea with abdominal distress. Cutaneous rashes, petechiae and angioneurotic edema may occur. By far the most distressing symptoms are asthma, respiratory depression and sometimes respiratory arrest.

Paradoxic tachycardia may develop when the drug is used in the treatment of auricular fibrillation. This can be prevented by the previous or simultaneous use of digitalis. Embolism or embolic phenomena have been reported from quinidine when used to treat longstanding and persistent auricular fibrillation. Functional auricular diastole in auricular fibrillation and in auricular flutter predisposes to clot formation in the auricular appendages. The clot may be expelled into the general circulation when the arrhythmia is corrected with quinidine and auricular systoles reappear.

No specific antidote for quinidine intoxication has been found. Caffeine with sodium benzoate in 0.5 gram doses given intravenously or intramuscularly is perhaps the most effective. Metrazol, benzedrine, nikethamide and picrotoxin have been shown by Wiseman to counteract some of the depressant effects of quinidine.

Mode of Administration

Quinidine may be given orally, intramuscularly or intravenously. The intravenous method is dangerous and should be reserved for special cases in which a rapid effect is expedient. The oral route is the safest and most commonly used. In each case a 0.2 gram test dose should be administered and the patient observed for reactions which occur in six to eight hours if at



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all. If the patient is not sensitive to the drug, 0.4 gram should be given every two hours until the arrhythmia has been corrected or until a total of five doses (2 grams) has been administered. This course may be repeated on the second and third day if necessary.

The drug should be stopped if toxic symptoms develop. After the arrhythmia is abolished, 0.2 gram two or three times per day should be administered for one week and then the drug should be stopped entirely. If the arrhythmia is recurrent, however, a maintenance dose must be selected, which is the smallest amount necessary to control the arrhythmia, usually 0.2 gram two or three times daily. There is no standard dose for quinidine and each case must be treated individually. It is safe to give up to 4 grams in twenty-four hours in divided doses.

For a more rapid effect intramuscular doses of quinidine sulfate or hydrochloride may be employed. The dosage schedule is the same as that for oral use. Recently it has been shown that the drug may be made more soluble by combining it with urea and antipyrine (quinidine hydrochloride 15 grams, antipyrine 15 grams, urea 20 grams, distilled water to make 100 cc.) for intramuscular use.

In cases of pulmonary congestion purely secondary to ventricular tachycardia, quinidine may be given cautiously by vein, 4 grams in 500 cc. of 5 per cent glucose at a rate of 10 drops per minute. Caffeine with sodium benzoate should be on hand to counteract any collapse reactions to the intramuscular or intravenous use of quinidine.—THEODORE R. SHERROD, PH.D.

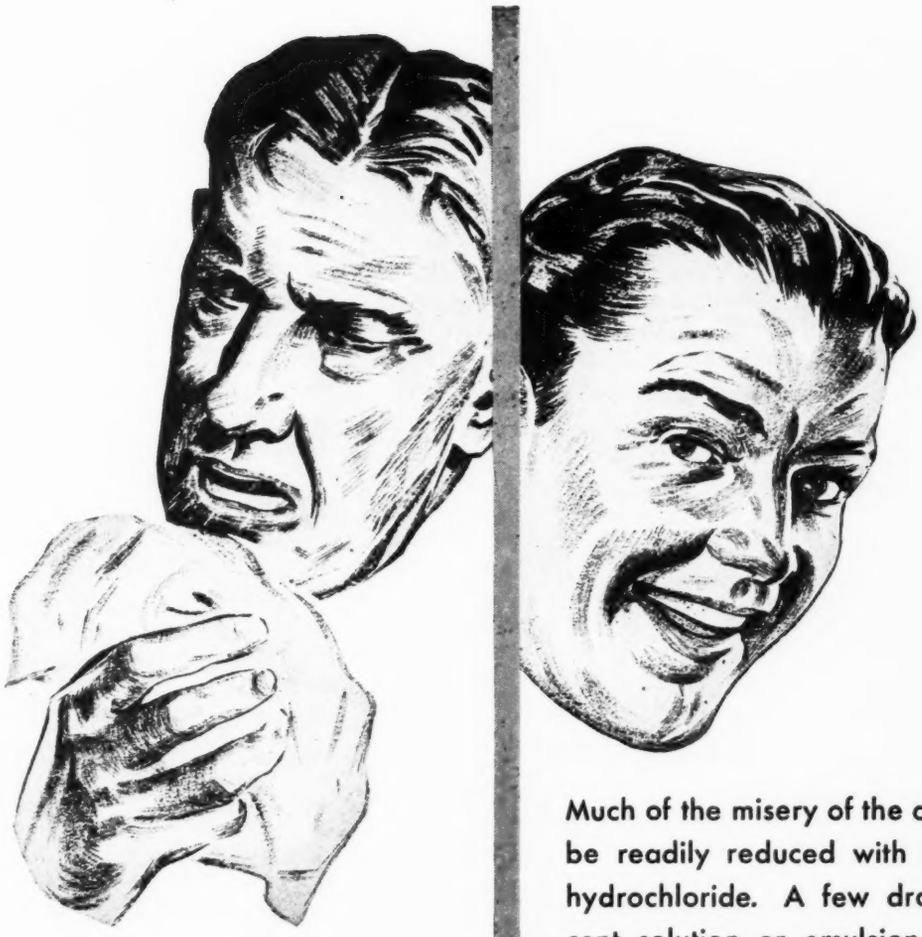
CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Angiocardiography

In an editorial on "Angiocardiography" in the September 1948 issue of *Surgery, Gynecology and Obstetrics*, Dr. Marcy L. Sussman discusses succinctly the procedure, its possible dangers, and its value. "Angiocardiography is the roentgenographic examination of the heart and great vessels following the intravenous injection of radio opaque material." Its success "depends upon a well integrated team of workers." In adults 40 to 50 cc. of 70 per cent diodrast must be injected rapidly. At present the author takes two roentgen exposures per second routinely, but, in some cases, he takes an exposure at a preset phase of every cardiac cycle, or motion pictures of the fluoroscopic screen. Ordinarily, reactions to the procedure are mild and transitory if careful screening and testing for individual sensitivity have been done. Contraindications are: (1) definitely allergic individuals, (2) those who cannot tolerate a rapid drop in blood pressure, and (3) severe liver or kidney damage.

The major value of angiocardiography is in the delineation of the heart and great vessels. Successively visualized are the superior vena cava, right auricle and ventricle, pulmonary artery and its branches, the pulmonary veins, left auricle and ventricle, the aorta and the branches arising from its arch. Thus differentiation of aneurysm from mediastinal tumor is possible. In various thoracic diseases, such as tuberculosis and tumor, the pulmonary vascular tree is altered. The author's interest in this technic



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has been chiefly in lung cancer. He states that it may be of diagnostic value "when bronchial neoplasm is suspected but is not proved even by bronchoscopy." Congenital abnormalities of the cardiovascular system, such as coarctation of the aorta, ductus arteriosus, tetralogy of Fallot, Eisenmenger complex, are often clarified by angiocardiography.

The integrated use of an accurate history, careful physical examination and, when necessary, such special technics as cardiac catheterization, angiocardiography and microplethysmography permits a complete anatomic and physiologic diagnosis in most cases with congenital cardiovascular lesions, and "the continued use of these methods will inevitably increase our understanding of, and diagnostic acumen in, cardiovascular diseases."—SIDNEY M. SAMIS, M.D.

Dermatology—International Outlook

R. M. B. MacKenna of London, as reported in the *Journal of the American Medical Association,* Dec. 27, 1947, feels that there is danger in some countries lest dermatologists lose their independence in the corporate body of medicine, for many physicians seem eager to incorporate dermatology in their own purview. Further, industrial medicine is now recognized as a specialty, and dermatologists will have to beware lest they are more and more excluded from this field, which is so fruitful in dermatological experience.

The volume of dermatologically important material published in the ever increasing numbers of excellent nondermatological journals makes it difficult for a dermatologist to keep abreast of and to assess these contributions, although he can follow the purely dermatological publications. To bridge this growing defect the author suggests an international dermatological abstract journal, with each paper evaluated first by a specialist in the field in which the paper primarily deals (because of the increasing technical nature of current periodicals) and, second, by a dermatologist. The increasing interest in dermatology manifested by physiologists, biochemists and others makes this a useful period in which to launch this periodical. It should lead to much greater collaboration among the various specialties.

In clinical dermatology, the author points out the contribution that preventive measures make to the control of dermatological entities and the importance of the common dermatoses during World War II. The low incidence of typhoid, typhus, malaria, dysentery, smallpox and all the great scourge diseases is cited. Four factors leading to control and decreased incidence of skin disease, for which the dermatologist cannot take special credit, are (1) modern and increasing use of plumbing, showers, hot and cold water, (2) good quality cheap soap, (3) washing of clothing and bedding, (4) higher standards of personal hygiene.

To prevent disease in his community, the dermatologist should first assess through correlated surveys the extent of the problems to be confronted, since there is little or no accurate knowledge of morbidity rates in skin disorders. This should be followed by consideration of the six possible etiologies of cutaneous disease: (1) genetic, (2) bacterial, fungus or virus, (3) biochemical, (4) psychologic, (5) allergic and (6) nutritional. Some difficulties inherent in discovering these causes are discussed, with

references to recent advances, such as the demonstration that barbers' implements are an important source of ringworm of the scalp.

The biochemical aspects of skin disease, especially the seborrheic states, with recent emphasis on the rôle of the androgens and estrogens, and the control of acne vulgaris with these substances are cited, with a discussion as to the possible mode of action.

Education of general practitioners and the laity is considered an important step in the prevention of the psychosomatic skin diseases, along with the extension of the dermatologist's own knowledge in the field. But the author warns that many patients must, from time to time, escape from their environment and, if the skin happens to be the "organ of stress," there is danger of grave psychosis if the skin is used as an organ of "escape." The relation of allergy to psychosomatic ills in dermatology is discussed, with the observation that America knows more than England about allergy.

The recent use of vitamin A_2 (calciferol) in the treatment of tuberculosis is discussed. Although it was thought to cure lupus vulgaris associated with tuberculosis of the lungs, it failed to cure the latter and may also have caused kidney damage.

The hope is that antibiotics, emulgent bases, radioactive isotopes, and endocrine therapy may play increasingly more important rôles in therapy, along with a plea for more occupational rehabilitation of skin disease sufferers. —E. D. ROSENFELD, M.D.

The Use of Benadryl in 100 Cases

The *U.S. Naval Medical Bulletin* for September-October 1947 reports an interesting review of 100 cases treated with benadryl. The authors, Barksdale and Hall, prescribed benadryl in 100 cases for the following conditions:

Poison Ivy—Except for three cases, the average duration of treatment was five days. The authors feel that this is a decrease in time compared to the use of other drugs. Also, the patients seemed more comfortable while on benadryl.

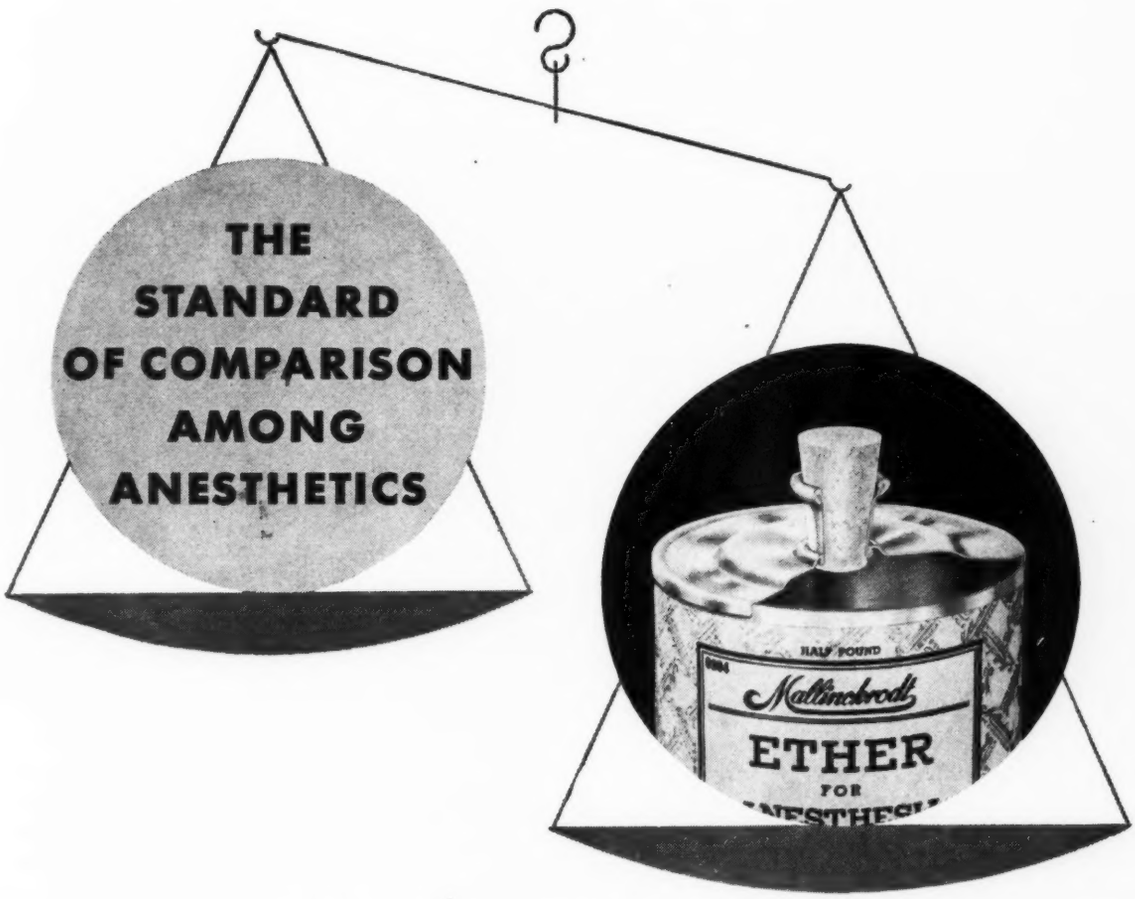
Chronic Urticaria — Twelve cases were treated, and all but two improved while on benadryl. However, complete relief was not obtained, even though the dosage in five cases was increased from 50 to 300 milligrams. The attacks were less frequent, of shorter duration and milder than when the patient was not taking benadryl.

Acute Urticaria — The fourteen cases in this group became asymptomatic with 150 milligrams a day, and the average duration of treatment was three days.

Penicillin Urticaria — Benadryl was found to be most valuable in the treatment of this group. It was administered to those patients who were receiving penicillin in massive doses over a twenty-five-day period for the treatment of syphilis. Benadryl was found to eliminate urticarial symptoms completely within forty-eight hours.

Benadryl was used with some effect in miscellaneous urticarias, atopic dermatitis, erythema multiforme, scabies, psoriasis and hay fever. Of four cases of hay fever, three had some relief. Drowsiness can be counted as the major side effect of the drug, but in only six of the 100 patients was it severe enough to cause complaint. Other side effects were nausea, tremor, dizziness, nervousness, headache, blurring of vision, conjunctivitis and contractures of the arms and legs.

In conclusion, the authors state that the drug is of most value for acute urticaria, including that due to peni-



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cillin. It is of some help in chronic urticaria, shortens the recovery period of poison ivy dermatitis, and in generalized atopic dermatitis there is sufficient subjective improvement to justify the use of the drug.—IRVING GOTTSEGEN.

Applied Photography

Photography is playing an increasingly important rôle in the medical sciences, it is reported by Hansell and Ollerenshaw in an interesting article, "Applied Photography—Relation of the Photographic Department to the Teaching Hospital," in the *Lancet*, Nov. 1, 1947. (London, England.)

The authors make a plea to hospitals, in which enthusiasm for a medical photography department is increasing, to continue their interest, and they urge a revival of interest in hospitals where such interest may be declining.

One of the most important reasons for a medical photographic department is its teaching potentiality. For this reason, such a department should be staffed by experts.

The two primary functions of a medical photographic department are: (1) production of routine record photographs of the highest quality and (2) adaptation and application of those records to medical education in its widest sense.

Under the processes of routine recording, one finds the rare case and the normal or usual case, the latter being the bulk of recorded material. A record should be made before, during and after treatment, thus providing teaching material, as well as a record of progress.

Another subdivision, under routine recording, is the serial photograph, in which it is attempted not only to produce comparable pictures but also to introduce a clinically significant time interval between them. This procedure may be used to assess progress and may have an influence on treatment. Motion pictures are of the greatest value in assessing the progress of cases in which movement is involved.

The next primary function of the medical photographic unit is the production of teaching aids. Among these are the following:

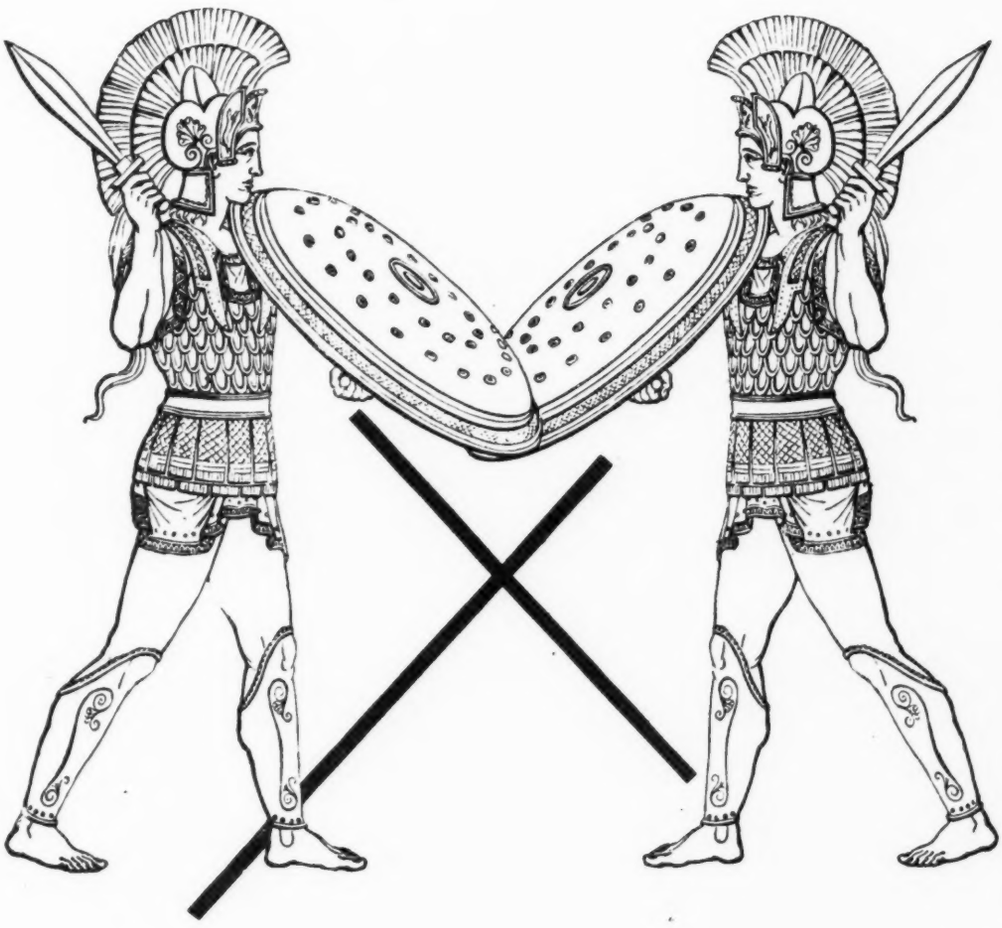
Displays. The essentials of a medical display should be clarity and simplicity, with the object of displays being the stimulation and not the complete satisfaction of the appetite.

Library Card. This consists of extensive photographs on large cards which should be used by the student alongside his textbooks.

Notebook Illustrations. Batches of cheap prints should be made for distribution to the student. These are especially effective for the illustration that is too elaborate for rapid copying.

Lantern Slides, Filmstrips, Motion Pictures should make up the other forms of teaching aids.

In conclusion, the authors mention the medical artist as an important member of the unit. Through him, unwanted detail may be eliminated, and one drawing may embody facets of several cases. The artist can collaborate with the photographer in many ways. The draughtsman has a place in the production of teaching aids through layout of displays, production of continuity frames for filmstrips, and in the supervision of animation sequences for motion pictures. Although we have pioneered in all of this in American medicine, there are still too many hospitals in this country which treat medical photography as a luxury instead of a necessity.—IRVING GOTTSEGEN.



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1. Editorial: J. A. M. A. 129:74 *(Sept. 1)* 1945

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FOOD SERVICE

Conducted by Mary P. Huddleson

WHAT PRICE CENTRALIZATION OF FOOD PRODUCTION

NENA D. OSTERUD
Administrative Dietitian
King County Hospital
Seattle

FOR the last twenty-five years I have been for the most part a hospital food production manager. When I start reminiscing, I can recall the thrills I used to get when I was asked as a young dietitian to show visitors through the kitchen of the state hospital in which I was employed. Particularly do I recall the thrill I had when Effie Raitt and Ruth Lusby came to see how their former student was doing.

The kitchen was a complete unit in itself, a building well apart from the wards. It had a wainscoting of white glazed tile on its pearl gray walls. It had a white tile floor and its almost-new 100 and 150 gallon steam-jacketed kettles shone. The bake oven was as large as a large living room, and on its two decks which we could pull out on tracks into the bakeshop we could bake 500 loaves of bread. We were serving 2000 people, 6000 meals a day.

AND THEN WHAT HAPPENED?

I was proud of the clean, bright kitchen and of the patient-helpers who had just returned from their semiweekly baths, shaves and hair trims; of the 150 gallons of soup and the 100 gallons of beans, and of the good fresh bread, all being given the last touches before leaving the kitchen for the wards. But "pride goeth before a fall," and great was my chagrin because something had happened to that food between the time it left the kitchen and the time we saw it being served on the wards.

The soup had little gray globules of fat riding unpleasantly on its surface, the beans looked dejected on the gray aluminum plates, the bread had been cut into "hunks," the stewed apricots were in a state best described as a mess, the good sugar cookies had not been gently handled, and the tea was ——!

Not so long ago, I chanced to read an article published in one of the hospital journals which had been written by a man who thought himself qualified to be critical because, as he said, he was an efficiency expert by profession, and he had just been a hospital patient. I have forgotten the name of the article and the author's name, but one of his statements is seared into my memory.

He said that he could not understand why his wife who had had no training could serve such good food while the dietitian with four years of home economics training plus another year in a hospital internship could not turn out even fair food. In fact, he said, the food he had had in the hospital was bad! Periodically, like an old dog, I have to go out and dig up that distasteful bone and worry it around.

Unfortunately, there is quite a bit of truth in his statement. The dietitian, in spite of her training, in spite of her knowledge of the technics of food production, in spite, too, of the beautiful equipment which through the years has been perfected to help her solve her many problems, still finds insuperable handicaps to serving foods as the patient is accustomed to receiving them at home.

Why should this be? After all, hospital food is simple food. It has to be simple because sick people prefer simple food and the doctors order it so. Often, the dietitian cannot even use a few grains of salt to help bring out its flavor. Just as simple music depends on the clear beauty of single notes and on simple chords and melodies, rendered by a master, to give delight to the listener, so simple foods depend upon perfection at the time of service to tempt the fickle appetites of patients.

In his own home, the patient is accustomed to reach over to the toaster on the breakfast table and remove the just-done piece of toast; his breakfast eggs can be served to him in a moment from the time they have reached just the state of perfection he desires, and so on. Need I remind you that this standard is a physical impossibility for the hospital food production manager under present conditions?

We pride ourselves that we train our cooks and that we follow standard recipes to the last detail, but there is that one last and most important detail, the last direction given on the recipe card, "garnish and serve *immediately,*" which we cannot carry out.

POOR SYSTEM AT BEST

At King County Hospital, Seattle, we have heated food trucks, we try to hurry the food from the ovens and ranges into those trucks and then hurry the trucks to the floors. We have a schedule that we struggle to keep and we try to serve the trays as quickly as possible, but even if everything goes just "according to Hoyle" we can serve only about two

trays a minute, and those wards hold from sixty to ninety patients.

Divide sixty by two and you find that more than thirty minutes have elapsed from the time the truck reached the pantry until that last baked potato is on the tray ready to go out. Even with our beautiful, stainless metal, thermostatically heat-controlled food truck, expensive as its purchase was, do you know what that sixtieth potato is like? Is it a fine, mealy baked potato? Of course not. It is a rather soggy steamed potato with its jacket on, or so the patient thinks. Consider those lamb chops, that slice of roast beef. Certainly, we can now keep our food hot, but is it the same food that Mr. X's wife could serve him?

We know that what Mr. X's wife has that we do not have is proximity to the consumer. For us to get closer to our consuming public we shall have to make ourselves heard in the language of the hospital planner and the architect. Perhaps when we speak that language fluently, we shall no longer be just those rather queer women called dietitians who see to it that food is weighed out in minute quantities on gram scales. Perhaps then, instead of seeking advice from men who do not know the technics of food production or from those who know the problems of the hotel or restaurant rather than those of the hospital, the planners will turn to us.

We have managed to get out of the diet kitchen into the main kitchen, and we know that hospital food is better for that. We have even managed to improve the kitchens, which are no longer tucked away in dark basements with the steam pipes, but as a result of our efforts we have succeeded in getting into mass production of a commodity, food, which should not be handled that way. The most necessary thing for us to do before we can take the next step in improving the food served to hospital patients is to eliminate the long delay between completion and consumption.

The problem that existed for us twenty-five years ago still exists, and while we have made many improvements, people when they feel called upon to praise us still say "Yours is the best *institutional* food I have ever eaten." I believe that in the years to come we should strive to eliminate that adjective. I would like to be told that our food is *good food.*

WHO WILL TRY DECENTRALIZATION?

MARY W. NORTHROP
Chief Dietitian
King County Hospital, Seattle

AT FIRST thought the suggestion made in Miss Osterud's article—that food preparation in large institutions should be decentralized—seems impractical and extravagant. Certainly, it is out of line with the trend of the past several decades, and one would think it would require more floor space, more equipment, more personnel and more supervision. Closer examination, however, indicates the probability that this is not the case and that serious consideration should be given to a reversal of the trend toward centralization.

Years ago, dietary departments were divided into multiple kitchens based on differences in function. It is here suggested that they be so divided again, but that the division should be based on location. As an example, consider this same 500 bed hospital, with its present conventional plan, and then as it would be replanned for decentralization of cooking.

This is a multistory building with one pantry near the center of each floor. Two offices are used by ward dietitians, one in the upper half of the house, and one in the lower half. Dishwashing is centralized in the main kitchen, an unsatisfactory mismatch with decentralized tray service. Unsatisfactory, also, is the fact that the nursing department has no refrigerators other than those in the pantries for medicines, biological supplies, and ice, with the result that the pantries can never be locked.

COOKING IN WARD KITCHENS

Cold food is sent to the floors in covered dish trucks, and hot food, in electrically heated food trucks, from the central dietary department on the ground floor. Toast and tea are the only foods prepared in the pantries. Food for special diets is prepared in the main kitchen and served with the other trays under the supervision of the ward dietitians. It is a thoroughly conventional dietary department planned for centralized food preparation and decentralized service.

Decentralization would result in a different plan of the building. There would still be a central dietary department with storage facilities, meat cutting and vegetable units, and bakeshop. So far, no change. There would be a cafeteria for personnel and a kitchen in which to prepare food for that cafeteria. Cooking for patients, however, would be done in three ward kitchens, located on the second, fifth and eighth floors, each planned for central tray service and each serving three floors by means of short-run conveyors or dumb-waiters.

SUPERVISION EASIER

In effect, there would be three small hospitals, except that meat and vegetables would arrive in the kitchens ready for cooking, and desserts and baked goods (since these do not deteriorate within reasonable time and distance) would be ordered from a central unit. Probably it would also be desirable for the cafeteria kitchen to supply the ward kitchens with soup stock and rendered fat. The three ward kitchens would require only a cook's unit, a pot and pan sink, and

facilities for tray service and dishwashing.

Supervision would be much easier than in the present department with its complete decentralization of service because there would be four places to watch instead of ten. At present, five ward dietitians spread out from two offices to cover nine floors. Six dietitians would provide full-time supervision for three units, and the one additional person needed for this could be transferred from the main kitchen, where the load would have been greatly simplified.

One complete handling of cooked food would have been eliminated, to the great improvement of food quality, satisfaction and efficiency. The cook would serve the plates and would gain greater satisfaction and do better work as she thought of food in terms of people rather than trucks. The fact that food preparation in each kitchen would be for fewer than 200 people would make possible home-style cooking by the average woman cook, working with uncomplicated equipment. The lamb chop and the baked potato could go straight from the broiler or the oven to a plate already in motion toward the patient. Amazingly, it would cost less than centralization!

Supply costs would go down because of better control. Pay roll might be increased $30 a month by the fact that a larger number of cooks and fewer unskilled workers would be used, but the number of personnel would be unchanged. Thirty dollars a month is two-tenths of 1 per cent of the present department pay roll!

PAY ROLL RISE NEGLIGIBLE

Tray maids would be transferred from ward pantries to ward kitchens, and there is no reason to suppose that the number required to set up the same number of trays would vary materially whether this was done in nine units or three. There are now seven pantry maids on each shift. This would provide two each for the upper kitchens, and three for the second floor kitchen, which, as it happens, would be carrying the heaviest load.

In addition, each ward kitchen would need a cook, a cook's helper and a pot washer—a total of nine for the three kitchens; but the main kitchen, relieved of cooking for patients, would release nine people—a cook, two helpers, two special diet cooks, two truck women, and two dish washers.

Comparison of Major Equipment Costs

	3 ward kitchens would need	Substitute for	Purchase Additional
Range sections	6		6
Ovens	9	6 from kitchen	3
Steam kettles	3	2 from kitchen	1
Mixers	3		3
Pot sinks	3		3
Sinks	3	2 from kitchen	1
Refrigerators	3	2 from kitchen	1
Coffee urns	3	3 from kitchen	0
Dishwashing units	3	9 from pantries	0
Toasters	6	9 from pantries	0

Floor space requirements, while differently distributed, would be less than with the conventional plan. Nine ward pantries now total about 2450 square feet, and they have no dishwashing units. When such units are installed, about 100 square feet, now in an adjacent room and used for another purpose, must be added to each pantry. Ward dietitians and their students need more than their present 250 square feet of office space. The present total, then, plus dishwashing space, is 3600 square feet. Each of the three ward kitchens would need about 1200 square feet of space apportioned as follows:

Cook's unit	250 square feet
Tray set-up and salads	450 square feet
Scullery	50 square feet
Dishwashing	150 square feet
Storage	100 square feet
Office	200 square feet

Three such units would require just the same total amount of upstairs space as the conventional plan. There would be a saving downstairs inasmuch as the main kitchen would need fewer ovens and steam kettles (150 square feet off the cook's unit); the special diet unit could be entirely eliminated (300 square feet), and no parking space would be needed for heated food trucks (500 square feet).

EQUIPMENT COSTS LESS

Now are you ready to be convinced that *major equipment costs* would also be less? Let us consider the figures in the accompanying table.

These purchases will cost seven or eight thousand dollars, but we can cross off the purchase list six dishwashing units and three toasters and we shall have no need for nine stainless metal electrically-heated food trucks, worth in themselves almost as much as the whole list. Actually, those stoves cost us nothing! It sounds like financing by "Mother" in "Life With Father." What we are proposing is, in effect, a combination of the two usual systems of tray service, a sort of decentralized central service.

We could increase efficiency and improve food. We could save money on supplies while spending very little additional on pay roll. We would be using no more equipment and less floor space.

We believe that all it will cost is the courage to dare.

FOOD FOR THOUGHT

Food Prospects

People in the United States are not eating quite so much food as they did last year and the year before, chiefly because last year's smaller feed crops have cut the production of meat, milk and eggs this year, according to the Bureau of Agricultural Economics, USDA.

Though feed crops are larger this year, they will not show up in larger supplies of meat and other livestock products on markets until 1949.

Even so, the average U.S. citizen is eating more food than he did before the war. Food consumption in 1948 is expected to be 12 per cent larger than the 1935-39 average. Even though supplies of most livestock products are down from the highs of recent years, this country is consuming more of these foods than in the late 1930's.

Sour Cream Sauces

Sour cream can be used to make a variety of sauces or dressings, hot or cold, for many of the vegetables now plentiful on markets and in gardens, cookery scientists of the U.S. Department of Agriculture remind us. If cream happens to turn sour, it should be used promptly, never wasted. Either "home-soured" cream or the sour cream especially prepared by dairies and for

(*Continued on Page* 124.)

Menus for November 1948

LaJean Sessions
Logan Latter Day Saints Hospital
Logan, Utah

1
Grapefruit Half
Soft Boiled Eggs
•
Swiss Steak
Parsley Buttered Potatoes
Buttered Peas
Sliced Tomato Salad
Jellied Mincemeat Pudding
•
Cream of Asparagus Soup
Grilled Cheese Sandwiches
Cooked Vegetable Salad
Olives
Canned Apricots

2
Tomato Juice
Omelet
•
Meat Loaf
Baked Potatoes
Harvard Beets
Lettuce Wedge With
1000 Island Dressing
Baked Apple With Cream
•
Clam Chowder (large)
Fruit Salad
Cinnamon Rolls

3
Casaba Melon
Poached Eggs
•
Beef Roast With Gravy
Mashed Potatoes
Baked Squash
Celery Sticks
Norwegian Prune Pudding
•
Stuffed Green Peppers
Creamed Carrots
Peach and Cottage Cheese
Salad
Devil's Food Cake

4
Orange Juice
French Toast With Sirup
•
Liver With Chile Sauce
Escalloped Potatoes
Green Beans
Salad Bowl
Pineapple Upside-Down
Cake
•
Meat and Noodle Casserole
Molded Grapefruit Salad
Cup Cakes
Baked Pears

5
Stewed Prunes
Soft Boiled Eggs
•
Baked Salmon
Au Gratin Potatoes
Spinach With Lemon
Tomato and Lettuce Salad
Tapioca Pudding
•
Vegetable Pie
Celery Sticks and Olive
Relish Plate
White Layer Cake
Bing Cherries

6
Grapefruit Half
Scrambled Eggs
•
Beef Patties With
Mushroom Gravy
Baked Potatoes
Buttered Lima Beans
Tossed Green Salad
Coconut Cake
•
Creamed Chipped Beef on
Toast
Combination Vegetable
Salad
Cookies
Seedless Grapes

7
Tangerines
Bacon
•
Veal Roast With Gravy
Baked Yams
Creamed Asparagus
Celery Hearts
Strawberry Ice Cream
Sponge Cake
•
Cream of Potato Soup
Egg Salad Sandwiches
Lettuce and Tuna Salad
Fruited Gelatin With
Whipped Cream

8
Applesauce
Poached Eggs
•
Chicken à la King
on Hot Biscuits
Whole Carrots
Lettuce Wedge With
1000 Island Dressing
Banana Cream Cake
•
Escalloped Potatoes and
Frankfurters
Pear and Orange Salad
Vanilla Ice Cream
Frosted Graham Crackers

9
Pineapple Juice
Scrambled Eggs
•
Baked Ham
Parsley Buttered Potatoes
Wax Beans
Cabbage Salad
Butterscotch Pudding
With Chopped Nuts
•
Vegetable Plate:
Baked Tomato
Creamed Peas
Whole Kernel Corn
Apple and Grapefruit Salad
Kadota Figs

10
Orange Slices
Soft Boiled Eggs
•
Lamb Chop With Minted
Applesauce
Duchess Potatoes
Peas
Cherry Cobbler
•
Spanish Spaghetti
Vegetable Salad
Fruit Cup
Small Cookies

11
Blended Juice
Hot Cakes With Sirup
•
Roast Beef With Gravy
Oven Browned Potatoes
Broccoli
Carrot and Raisin Salad
Creamy Rice Pudding
•
Split Pea Soup (large)
Waldorf Salad
Sugar Cookies

12
Grapefruit Half
Poached Eggs
•
Halibut With Tartare
Sauce
Creamed Potatoes
Baked Squash
Coleslaw
Lemon Meringue Pie
•
Macaroni and Cheese
Sliced Tomatoes
Angel Food
Apricots

13
Stewed Prunes
Soft Boiled Eggs
•
Ham Loaf
Baked Potatoes
Creamed Turnips
Sliced Tomato Salad
Apple Crisp
•
Cream of Pea Soup
Ground Meat Sandwiches
Cooked Vegetable Salad
Canned Plums

14
Orange Juice
Link Sausages
•
Fried Chicken
Mashed Potatoes
Peas and Carrots
Stuffed Celery
Caramel Ice Cream
•
Vegetable Soup (large)
Pineapple and Cottage
Cheese Salad
Chocolate Cake

15
Casaba Melon
Poached Eggs
•
Meat Balls
Duchess Potatoes
Spinach With Lemon
Lettuce Wedge With
French Dressing
Fruited Gelatin With
Whipped Cream
•
Escalloped Corn and
Tomatoes
Cress and Egg Salad
Baked Apples

16
Grape Juice
Omelet
•
Roast Beef With Gravy
Mashed Potatoes
Buttered Asparagus
Tossed Green Salad
Bread Pudding With
Maple Sirup
•
Cheese and Rice Croquettes
With Creamed Tuna
Cardinal Salad
Blueberry Muffins
Royal Anne Cherries

17
Grapefruit Half
Soft Boiled Eggs
•
Beef Stew With Vegetables
Noodles
Health Salad
Gingerbread With
Lemon Sauce
•
Sweet Potato Soufflé With
Link Sausages
Combination Vegetable
Salad
Lemon Wafers
Seedless Grapes

18
Frozen Rhubarb
Cornbread With Honey
•
Braised Liver
Escalloped Potatoes
Stewed Tomatoes
Carrot and Celery Sticks
Apple Cobbler
•
Chicken and Noodle
Casserole
Molded Pea and Cheese
Salad
Peaches

19
Tangerines
Poached Eggs
•
Salmon Loaf
With Parsley Sauce
Baked Potatoes
Green Beans
Tomato and Cottage
Cheese Salad
Cream Puff With
French Filling
•
Vegetable Chowder (large)
Fruit Salad
Molasses Oatmeal Cookies

20
Tomato Juice
Scrambled Eggs
•
Swiss Steak
French Fried Potatoes
Peas
Lettuce Wedge With
1000 Island Dressing
Chocolate Pudding With
Marshmallows
•
Creamed Chipped Beef
on Toast
Waldorf Salad
Apricots

21
Applesauce
Bacon
•
Pork Roast With Gravy
Candied Yams
Cauliflower
Tossed Green Salad
Vanilla Ice Cream
•
Cream of Tomato Soup
Macaroni Salad
Sliced Cheese
Radish Roses
Cup Cakes

22
Canned Plums
Soft Boiled Eggs
•
Individual Chicken Pie
Molded Orange and
Cranberry Salad
Graham Cracker Pudding
•
Escalloped Potatoes and
Ham
Grapefruit and Avocado
Salad
Bing Cherries

23
Orange Juice
French Toast With Sirup
•
Beef Roast With Gravy
Mashed Potatoes
Brussels Sprouts
Tomato and Lettuce Salad
Floating Island
•
Cheese and Noodle Loaf
With Creamed Vegetables
Carrot and Raisin Salad
Peaches

24
Grapefruit Half
Poached Eggs
•
Heart Patties With
Tomato Sauce
Baked Potatoes
Mashed Squash
Lettuce Wedge With
Mayonnaise
White Cake
•
Vegetable Plate:
Sliced Beets
Baby Lima Beans
Asparagus Spears
Cabbage and Apple Salad
Fruit Cup

25
Pineapple Juice
Link Sausages
•
Roast Turkey With
Dressing and Gravy
Mashed Potatoes
Peas and Mushrooms
Cranberry Sauce
Celery Sticks
Pumpkin Pie With
Whipped Cream
•
Cream of Mushroom Soup
Cold Meat
Potato Chips
Molded Fruit Salad
Applesauce Cake

26
Orange Slices
Soft Boiled Eggs
•
Fillet of Sole With Lemon
Au Gratin Potatoes
Buttered Beets
Coleslaw
Norwegian Prune Pudding
•
Spanish Rice
Combination Vegetable
Salad
Sponge Cake
Pears

27
Casaba Melon
Omelet
•
Meat Loaf
Baked Potatoes
Stewed Tomatoes
Stuffed Celery
Marble Cake
•
Peas à la King on Toast
Sliced Orange
and Coconut Salad
Vanilla Wafers
Kadota Figs

28
Blended Juice
Bacon
•
Beef Roast With Gravy
Mashed Potatoes
Julienne Green Beans
Tomato Aspic
Chocolate Ice Cream
•
Turkey Noodle Soup (large)
Peach and Cottage Cheese
Salad
Plum Pudding With
Foamy Sauce

29
Grapefruit Half
Poached Eggs
•
Barbecued Frankfurters
Duchess Potatoes
Parsleyed Carrots
Tossed Green Salad
Boston Cream Pie
•
Beef Biscuit Roll With
Gravy
Combination Vegetable
Salad
Apricots

30
Apple Juice
All-Bran Muffins
•
Roast Lamb With Gravy
Mint Jelly
Mashed Potatoes
Peas
Grapenut Custard
•
Cream of Asparagus Soup
Fruit Salad
Cheese Slices
Date Bread
Cubed Gelatin With
Whipped Cream

Ready-to-eat or cooked cereals are offered on all breakfast menus.

sale in many city markets may be used in the following recipes:

Fried Tomatoes With Sour Cream Sauce. Sliced tomatoes, dipped in egg and crumbs and fried to a golden brown on both sides, are extra good dressed up with sour cream sauce. After lifting the fried slices to a hot platter, sprinkle a couple of tablespoons of flour over the fat left in the pan, mix well, then pour in a cup or a cup and a half of sour cream. Stir and cook slowly until thickened. Season with salt and pepper as desired. Then pour the hot souce over the tomatoes on the platter and serve at once.

Hot Sour Cream Sauce. This sauce is especially good with cooked broccoli, cauliflower or potatoes. To make enough for six servings, blend 1 tablespoon of butter or other table fat with 1 tablespoon flour. Then add 1 cup sour cream and ¼ teaspoon salt. Heat slowly and stir until thickened. Cover and cook over hot water for about five minutes. Finely chopped parsley, chives, or red or green pepper may be added to give color and added flavor.

Cooked Salad Dressing. Ingredients: 1 cup sour cream; 2 eggs; ½ teaspoon salt; ¼ teaspoon mustard; 1 tablespoon sugar; ½ cup vinegar; pepper if desired. To make: Beat the eggs very light, add the sour cream and other ingredients. Cook over hot water until thickened.

Detergent Characteristics

The "soapless suds" or synthetic detergent powders now being used so widely for dishwashing generally are excellent oil and grease removers and therefore useful for washing greasy pans and dishes, equipment specialists of the U. S. Department of Agriculture note.

But this characteristic is a disadvantage in washing linoleum, paint or furniture. Oil is an essential ingredient in linoleum and oil paint, also in many wood finishes. Washing with soapless detergents draws out some of the oil and thus causes drying of these finishes.

Even soap has a drying effect on linoleum and paint, so should always be rinsed off carefully. As for gasoline and other similar grease solvents, they should never be used on linoleum.

Frequent waxing and even occasional oiling are recommended to keep linoleum in best condition. If it shows signs of scarring, scratching or drying, an application of boiled linseed oil helps. Apply the oil to clean, dry linoleum. Let it stand for about forty-eight hours. Then wash off and wax.

Try Reversing the Plug

Have you ever received an electric shock from a metal lamp stand, a food mixer, or a washing machine? Does your radio sometimes act up with more static than usual?

Rural Electrification advisers of the U. S. Department of Agriculture suggest that as a temporary remedy you try removing the plug from the wall outlet and reversing it. Just turn it half way around and plug it in again. That may correct the condition.

The reason this simple remedy sometimes saves an immediate repair bill is that one side of your 115-volt circuit is grounded. Reversing the plug may connect the "leaky" wire to the grounded side, disconnecting the faulty side of the cord from the appliance.

It does not remove the fault itself, and REA recommends that this practice be followed only as an emergency measure.

How to turn refrigeration bills into good news

Can be done—if you put Meter-Miser compressors to work for you! Remotely installed with new or old refrigerated fixtures, these sealed-in-steel rotary units cut refrigeration bills 'way down and do it year after year. Proof? Ask any of over 4 million satisfied users. Better yet, call in your Frigidaire Commercial Dealer and get complete facts. Find name in Classified Phone Directory. Or write Frigidaire Division, General Motors Corp., Dayton 1, Ohio; Leaside 12, Ont.

Revolutionary Frigidaire Remote Meter-Miser backed by Special 5-Year Warranty

How the FRIGIDAIRE METER-MISER saves current, saves maintenance

Saves Current Because it's the simplest refrigerating unit ever built. Parts—made of the finest materials obtainable—are mirror-finished to reduce current-wasting friction to a minimum. Motor is specially cooled, maintains top efficiency even under peak loads. No pistons, piston pins, or connecting rods.

Saves Maintenance Because the compressor and motor are sealed in steel and oiled for life—damaging dirt, dust and moisture *can't* get in. No belts, no pulleys, no seals. Entire remote type Meter-Miser is 25% to 50% lighter than conventional units, can be lifted by one man. Uses Freon 12, the *safe* refrigerant.

Saves Space, Too—so compact, so attractive, can be tucked into almost any space you desire—can be hung from the ceiling, or placed on a shelf. Nothing to soil or tear customers' clothes.

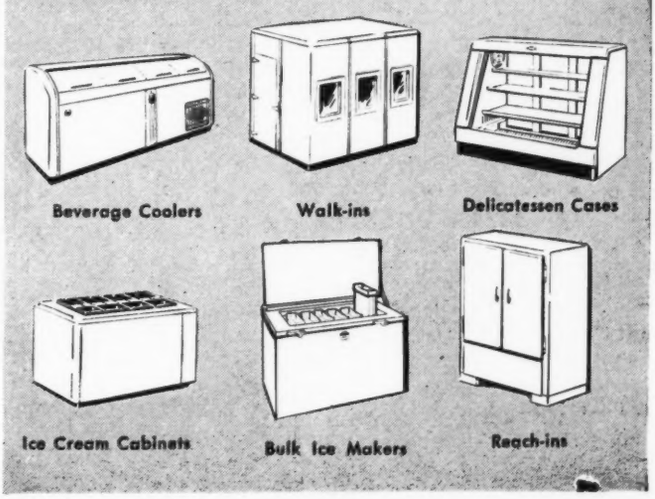
Three Basic Things to Look for When You Buy Refrigeration

A full line of *products* you can depend on, a *name* you can depend on, a *dealer* you can depend on. Get *all three* with Frigidaire.

You're twice as sure with two great names

FRIGIDAIRE made only by GENERAL MOTORS

FOR NEW OR REPLACEMENT USE WITH MOST REFRIGERATED FIXTURES



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MAINTENANCE AND OPERATION

WHAT GOOD MAINTENANCE CAN ACCOMPLISH

PAUL J. SPENCER
Director, Lowell General Hospital
Lowell, Mass.

THERE are few hospitals today that can afford to construct a new plant either by expanding facilities or by replacing obsolete buildings. When trustees view the cold, hard figures submitted by architects and consider the current value of a dollar translated into mortar and brick, compared with buildings now in use, they are inclined to go little beyond fund-raising efforts in providing the necessary facilities for our community hospitals.

To accentuate this situation, we are faced with the possibility of war and with the inevitability of a rationed economy in which the materials so needed by hospitals in their operation will be either impossible or very difficult to procure. It is from these points of view that we must approach the possibilities of good maintenance and all that can be accomplished in this direction to make our hospitals efficient, effective and able to weather the storms and stresses of the next few years.

New Englanders born and bred have often heard from their parents and grandparents the four cardinal Yankee virtues. Although they are fewer in number they were second only to the Ten Commandments in the everyday life of our forebears. Next to their religion, the older generation of Yankees set up these principles to live by: (1) eat it up; (2) make it do; (3) wear it out; (4) go without. From these basic characteristics a great country rose to its present scale of prosperity.

Faced with the difficulties already mentioned, it would be dangerous today, however, to apply these virtues to hospital maintenance owing to the relationship of repair and upkeep to current labor costs. Every hospital administrator has had to achieve a new sense of values in the face of hourly wage rates of today, and the maintenance of our hospitals has made us all look to new materials, new designs, new functional efficiencies that will reduce or eliminate maintenance to the highest degree possible.

It would be difficult to name any department that is not dependent on maintenance. Many times a day the laundry manager, the dietitian, the nursing service and all the technicians call upon mechanics to keep their services in operation. If these demands are to be reduced to a minimum we must have intelligent planning and supervision. A well qualified superintendent of maintenance saves his salary many times over. He is able to do this by bringing to the job ingenuity and resourcefulness in eliminating costly outside contract work; by having some skill on the drawing board, obviating many fees for engineers and architects; by supplying sound judgment as to the economics of the cost of care *vs.* the cost of replacement, and by his ability to draw up specifications of work and materials to ensure complete protection for the purchasing department.

PICKING A MAINTENANCE CHIEF

In the heating plant alone he can save enough fuel and electricity costs to pay for his own salary, provided he has made a thorough study of steam and power. A wise administrator appoints a chief of maintenance or a master mechanic only after he has interviewed a score or more qualified persons because he knows how important this function of hospital operation can be.

Obviously, good maintenance implies an adequate mechanical staff. It is important for the individual administrator to determine what mechanics he can keep busy the year round. A medium sized hospital should have one or two carpenters, perhaps two painters, an electrician, a plumber and several firemen. Smaller hospitals may be able to combine such skills in two or three men who are versatile enough to cover these trades. By having skilled mechanics we can ensure prompt, emergent repairs; avoid costly and irritating interruptions of routine services; prevent annoyances to employes, thereby protecting working morale; develop self-sufficiency in the plant, and save large amounts of money by avoiding the expense of contractor's fees. Skilled mechanics are often able to diagnose

Presented to the Administrators' Institute, Colby College, Waterville, Me., August 1948.

trouble in advance and by so doing prevent breakdown.

Preventive maintenance implies a rigid schedule of inspection and servicing. It is important to have a schedule of assignments for each mechanic to carry out for daily, weekly, monthly and annual services on all mechanical equipment. Nowhere more appropriately than in a hospital can we apply the old proverb, "A stitch in time saves nine." Slipshod maintenance indicates a slipshod hospital. Orderliness of procedure stresses a need for a system of repair requisitions and careful "follow through."

ADMINISTRATOR SHOULD INSPECT

The only way in which good maintenance can be carried out properly is to have the chief of that department constantly in touch with his workmen, but it seems to me even more important for the administrator to exercise an overall supervision. Hardly a day passes that I do not inspect all work in progress. This ensures that the job is being done correctly, that revisions and adjustments are made, and that suggestions for improvement are carried out while the work is in progress; it sharpens our eye for improving working conditions and efficient service to patients.

Up to this point we have only been considering the basic principles of good maintenance. From this point on let us assume we are not able to replace our obsolete or obsolescent existing plant and it has been decided, after careful thought, that the plant should be thoroughly surveyed, renovated and modernized in accordance with current standards.

The administrative survey should be made in cooperation with department heads. The maintenance chief, the superintendent of nurses, the dietitian, the housekeeper and all administrative officers should spend many hours in a detailed study of functional requirements and replacement. Keeping in mind that local conditions and individual situations will change these factors, let us think in terms of buildings or units that are twenty, thirty and forty years old or over and discover what we can accomplish by good maintenance.

In a building or wing that has been in operation for at least twenty years, you may well find that refrigeration is not efficient. If you are still using iceboxes you will readily see that elimination of ice and the labor involved will quickly pay for new electric refrigerators. You will find that old methods of sterilization by boiling water should give way to new technics of steam sterilization under pressure. You can eliminate many small sterilizers with one central autoclave and create a great deal of new working space.

Are nurses' stations well located and do they ensure privacy and control? If they do not, there are many types of prefabricated steel and glass partitions that are easily and economically installed. How effective is your communications system? Have you considered how many steps you can save with additional telephone instruments and an intramural dialing system, a public address system or patient-nurse intercommunication?

HOW ABOUT LIGHTING?

What sort of lighting fixtures do you have and do they give you maximum efficiency and economy? If they burn twenty-four hours a day you may cut your electricity bills in half with fluorescent fixtures and have double the wattage while doing it.

Redecoration is always an important factor and with the present emphasis on color therapy you will find not only that you can create a beautiful environment for patients but also that you can actually stimulate greater efficiency on the part of your employes by wisely selecting attractive hues for their working areas. Have you recently bought some of the attractive modern hospital furniture for your private rooms, thereby permitting you to sift the present furniture down through semiprivate and ward accommodations and even to employe quarters, discarding the worst that has more than outlived its usefulness and attractiveness?

Are you still washing dishes by hand on the floors? Consider the small automatic dishwashing units that can be purchased today and the personnel time saved by their installation, to say nothing of the attitudes of maids toward such equipment. Are your solutions, bedpans, urinals and basins exposed on open shelves or racks or have you procured closed steel cabinet space for cleanliness and proper segregation of equipment? How adequate is your ventilation for employe and patient comfort? Much can be accomplished by means of suction fans and utilization of ducts in diet kitchens and utility rooms. What is the condition of screens and storm windows on your twenty year old unit?

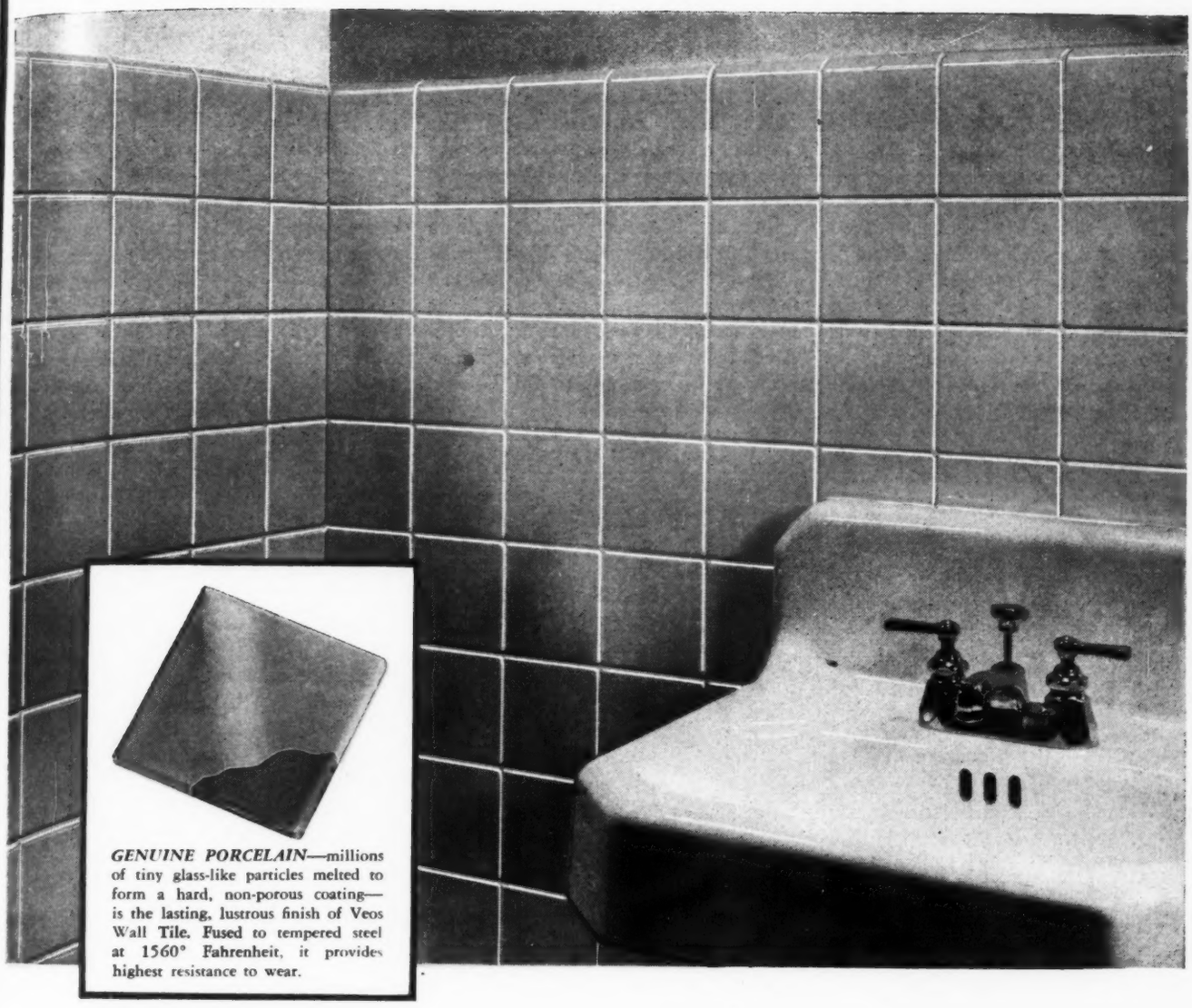
If you have a school of nursing it is quite probable that your twenty year old unit does not have adequate ward teaching facilities, which you can achieve by various adjustments. When you survey rooms that were designed for a function that is no longer needed you may be able markedly to increase your revenue by converting old blanket warming rooms, rooms with unused bathtubs, infrequently used reception rooms and solariums to additional patient accommodations.

When we approach construction that is at least thirty years old we should of course consider all of the foregoing and look for other factors in addition. Are drinking fountains available for patients and the public? An electric one in the corridor is most convenient and saves many a nurse's time. Utility rooms of thirty years ago were hardly designed to meet present needs. Old soapstone sinks can be replaced with stainless metal; elbow action cocks can be installed; additional counter space can be constructed, and hoppers, bedpan washers and other sterilizers can be replaced where needed. Floor diet kitchens may still contain the original installations. The plaster walls are hard to keep clean, the wood shelves are sticky and dirty, and a whole reevaluation of cleanliness and the proper flow of work should be made when such areas are being redesigned.

SMOKING AND DRESSING ROOMS

Thirty years ago employe lounges did not seem to be important and when most of the employes lived in there was little need for locker facilities. You may be able to clean out many basement "glory-holes" and with the addition of spray paint, fluorescent fixtures and new floor covering you will be able to make attractive smoking rooms and dressing rooms for employes who come in by the day. Wise selection of floor coverings, based on location, usage and cost, will eliminate much maintenance and provide an attractive setting.

Modern requirements insist on a multiplication of lavatories with elbow action cocks throughout the hospital to which doctors and nurses can have ready access for scrubbing when examining patients. The thirty year old building has few of these. Do existing toilet fixtures contain modern flushometers? Are ward and semiprivate patients adequately separated by cubicle curtains, eliminating un-



GENUINE PORCELAIN—millions of tiny glass-like particles melted to form a hard, non-porous coating—is the lasting, lustrous finish of Veos Wall Tile. Fused to tempered steel at 1560° Fahrenheit, it provides highest resistance to wear.

Tough tile for rough treatment

In washrooms, clinics, operating rooms, and dispensaries—wherever walls are subject to harsh treatment—it pays to have wall surfaces that are durable and practical. Armstrong's Veos Wall Tile is ideal for such places. It withstands many years of hard wear without losing its original beauty, and it won't crack, craze, chip, warp, or fade. It's remarkably easy to clean and keep clean, with a minimum of care.

The many practical advantages of Veos Wall Tile stem from its exclusive construction. Genuine porcelain—like that used for fine basins and tubs—is fused inseparably to a base of heavy gauge steel. The result is a combination of strength and beauty that means long wear and easy care—lasting satisfaction.

Veos tile can be installed economically and quickly. Since it weighs only one-third as much as clay-bodied tile, walls don't have to be reinforced to support it. And it goes up over a specially grooved fiberboard base that assures perfect alignment of tiles.

Armstrong's Veos Wall Tile comes in nine attractive colors and many sizes and shapes. Countless decorative designs are possible. Ask your local Armstrong contractor for full information about Veos Wall Tile or write to Armstrong Cork Company, Building Materials Division, 5710 Frederick St., Lancaster, Pa.

ARMSTRONG'S VEOS WALL TILE

Porcelain on Steel

wieldy floor screens that are always in the way? As flowers flow in for patients have you adequate provision for their care?

Your housekeeper is probably unhappy because her maids and porters do not have enough closets and sinks. In some hospitals it is difficult to find a clock and since an electric clock costs but a few dollars, it is most desirable to have them everywhere. In thirty years many ducts, pipes and vents have outlived their original purposes and you may be able to put them to many ingenious new uses.

Are you inconvenienced by having patients and employes using the hospital telephones for personal conversations? The telephone company will be glad to install booths which will take the load off your switchboard and provide privacy and convenience for this type of call. Outside the buildings, utilitarian and decorative railings will do much to add safety plus decoration.

Many authorities consider hospital buildings that are forty years old or more to be obsolete, or at least obsolescent. However, for our present purposes we will assume that for the next five years at least we shall have to live with such a unit. Perhaps it may be longer. When you have evaluated all the factors mentioned regarding twenty and thirty year old units, it would be well to have an expert in fire prevention survey the forty year old building to determine whether patients are adequately protected. He may recommend covering vents and installing automatic fire doors for stairways and corridors.

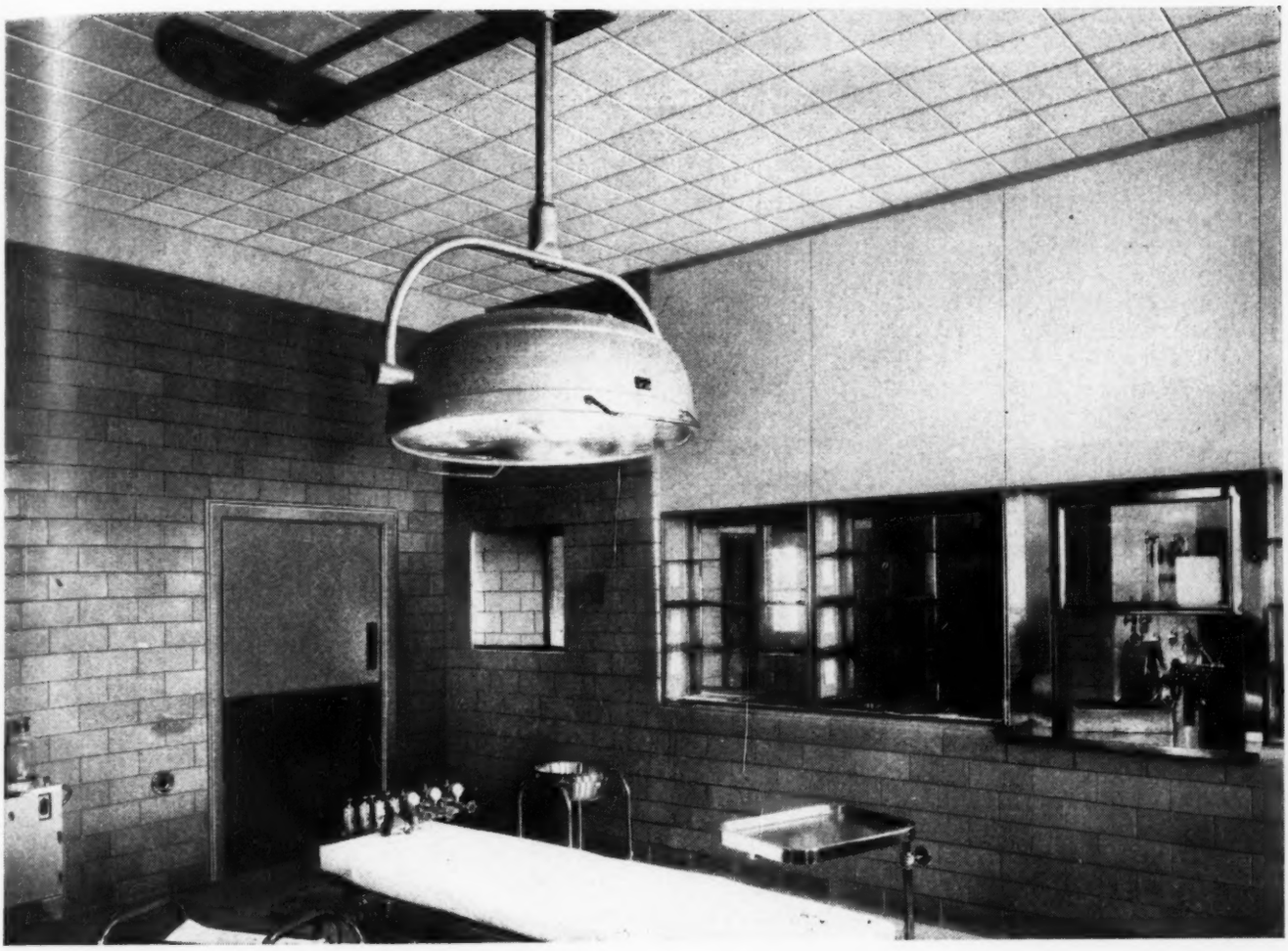
If the electrical wiring has not been renewed for the life of the building, old materials installed when building standards were less exacting may be a terrific hazard because of the possibility of short-circuiting. You have an obligation to protect your patients against fire and this must not be minimized.

Did the architect forty years ago install a laundry chute? If he did not, much labor and space saving can be effected by the use of perhaps an old unused dumb-waiter shaft. Do you have adequate waiting rooms in this old building? Perhaps you can adapt little used areas for this purpose. Forty year old walls of wood lathe and old plaster will require considerable repair and you may want to consider such substitute materials as wallboard for this purpose.

Above all, it is imperative that all new equipment for a forty year old unit should be selected and installed with a view toward eventual removal and use in new construction. When this is not possible, much thought must be given to "make do" substitutes that are inexpensive but will save labor costs and justify by their efficiency the new installation. Regardless of cost, never should we compromise with any situation that affects the life and welfare of our patients.

POSSIBILITIES IN GOOD MATERIALS

Administrators who are familiar with new materials will be more than ever interested in them in their relationship to the reduction of maintenance. For walls, there are attractive fabric covers which are washable and which will protect the plaster from crumbling and cracking. In areas of hard use there is a tile that is easily washed and requires no painting. Selection from the wide range of floor coverings, such as tile, linoleum, terrazzo and concrete, depends on the use and the area of location. More and more, it is important to have sound-absorbing materials on ceilings, which also greatly reduce maintenance and



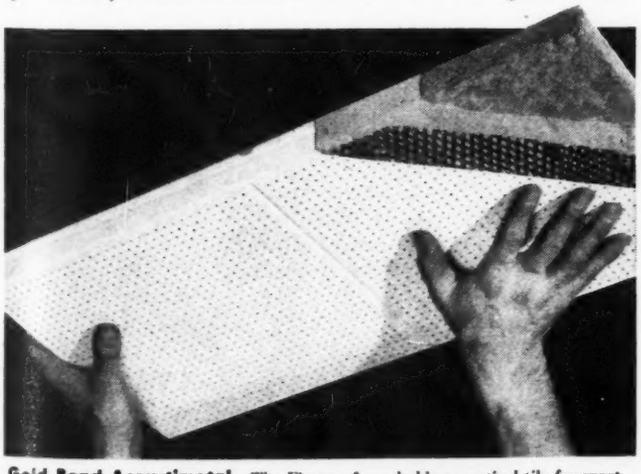
QUIET wanted in surgery!

DISTRACTING noise is softened to a whisper with this ceiling of Gold Bond Acoustimetal. Whatever the type of job—a new 10-million dollar hospital or the modernization of a small town clinic with a limited budget, Gold Bond Acoustimetal is the logical choice from every standpoint.

Of vital importance to hospitals, Acoustimetal is absolutely fireproof and sanitary. The metal surface is practically indestructible and comes with light-reflecting baked enamel finish that will take all the cleaning in the world. If special colors are desired, Acoustimetal may be painted without loss of its high sound absorption. The 12″ x 24″ tiles or "pans" are securely anchored to T-bar runners but may be readily detached for access to wiring and ducts.

Because Acoustimetal all but eliminates repair and maintenance expense, it will actually show savings over lower priced vegetable fibre products, over a period of time. An illustrative folder describing Acoustimetal in detail will be sent free upon request.

Factory-appointed Gold Bond Acoustical Applicators in all key cities insure highest quality workmanship.



Gold Bond Acoustimetal—The Fireproof, washable acoustical tile for exacting sound control.

You'll build or remodel better with

Gold Bond

NATIONAL GYPSUM COMPANY • BUFFALO 2, N. Y.

Over 150 Gold Bond Products including gypsum lath, plaster, lime, wallboards, gypsum sheathing, rock wool insulation, metal lath products and partition systems, wall paint and acoustical materials.

painting. Table tops covered with linoleum, plastics and stainless metal pay for themselves in the elimination of maintenance many times over in a couple of decades.

Good maintenance often involves special requirements that emanate from regulations promulgated by state authorities and professional organizations whose standards all of us strive to achieve. One of the great advances in the last two years has been new conceptions of nurseries and the preparation of milk formulas for infant feeding. It is amazing what good maintenance can do with an old unit. It is not difficult to erect inexpensive wallboard partitions, install Dutch doors and wash basins with elbow cocks, and lay floors of a substance that defies slipping under practically every condition and has the great virtue of being relatively inexpensive. Much can be done with new bassinets, with lights, counters and cabinets in these areas.

We need to have the proper psychological approach to all of these requirements. How many department heads and administrators resent the inspection of the hospital by outside persons who represent approving and accrediting bodies, health authorities, municipal, state and federal agents, and representatives of professional organizations? It seems to me that the proper attitude should stem from the administrator and that by his example and education department heads will come to see that these inspections should be not only welcomed but also eagerly sought.

It has been my practice to invite these authorities to survey our facilities from time to time so that we can improve our standards and make possible the most efficient and advanced patient care. By departmental conferences, and later through consultation with a cabinet of department heads, it is easy to accumulate collective, constructive criticism and enlist the necessary supporting teamwork to bring these conceptions into material realization. Naturally, this all presupposes that we shall have full trustee support in our aims and objectives and this, of course, implies good salesmanship and education on the part of the administrator.

WORKING CONDITIONS ENHANCED

The satisfactions that all of us derive from our hospital work are deep seated and most of us would have difficulty putting them into words. If we seek to justify good maintenance and its far reaching accomplishments, it will not be difficult to prove that we have achieved excellent employe relations by markedly enhancing working conditions.

We shall discover that reactions are most favorable for patients are impressed by orderliness and cleanliness, as well as by the efficiency of those who give them professional care. We shall discover that the public responses are many and warm and that the visitors who come to us and see a well maintained plant, efficiently operated, will spread the gospel far and wide.

We shall find our trustees, as they go about the hospital and as they talk with their friends, swelling with pride because it has been their policy to see that the wherewithal to carry out good maintenance has been produced. We shall find as we stand aside and gain a perspective on the results of good maintenance that it has accomplished happy, efficient teamwork which in turn has brought better care and a higher quality of professional service to our patients than we have ever rendered before.

NEWS DIGEST

Announce Plans for Building Chicago Medical Center . . . Davis Attacks Nursing Report . . . A.M.A. Council Opposes Blue Cross-Blue Shield Move . . . Cites Flaws in California Ruling on Salaried Doctors

$50,000,000 Building Plans for Chicago's Medical Center District

CHICAGO.—More than $50,000,000 for building construction to take place within the next five years is now in the blueprint stages for the medical center district on Chicago's West Side, according to an announcement made last month by officials of the University of Illinois.

Planned construction will bring the medical center district one step nearer to the ultimate goal of $300,000,000 valuation which has been predicted for it by Dr. Walter H. Theobald, president of the medical center commission, the announcement said.

The present value of land, buildings, equipment and facilities in the medical center district is estimated at nearly $100,000,000, largest in the world in terms of money invested in educational and hospital facilities, it is estimated. Building projects now on the drawing board include the $15,000,000 Veterans Administration hospital, ground for which will be broken some time in 1949. The 1000 bed hospital will be located on a site near three medical schools and affiliated institutions, enabling the hospital to obtain an outstanding staff and to extend to patients the best in medical care, the university announcement said.

Another large project will involve improvements and expansion of physical facilities of the Cook County Hospital group. Cook County voters passed a $7,000,000 bond issue last spring for a program that will include the construction of a new residence for interns and extensive modernization of the present buildings. Construction of the state's new $6,000,000 tuberculosis hospital also will be started next year.

The most immediate construction project which will be undertaken in the district will be the breaking of ground this fall for the Institution of Tuberculosis Research. The $361,000 institution will produce and distribute the vaccine, BCG, which has proved to be highly effective in preventing tuberculosis in children as well as adults. It will be operated jointly by representatives of the University of Illinois, the Research Foundation, and the Municipal Tuberculosis Sanitarium.

Loyola University will spend $5,750,000 for erection of a building to house its school of dentistry and the Stritch School of Medicine. The university is now conducting a $12,000,000 fund campaign, one-fourth of which is being sought this year.

Other institutions in the medical center district which are planning construction within the next five years are Presbyterian Hospital, the Chicago Medical Society, the Cook County Graduate School of Medicine, and the West Side Professional Schools Y.M.C.A.

In addition, the University of Illinois is preparing recommendations for its building program to submit to the state legislature. The university building committee is now considering an $18,700,000 construction program which would include an addition to the 428 bed Research and Educational Hospitals, a classroom and laboratory unit addition to the colleges of medicine, dentistry and pharmacy and a nurses' residence and school. Private financing is also being sought for a student residence.

Architects Ask Written Program for Each Job

ATLANTIC CITY, N.J.—Assembled in conference here preceding the American Hospital Association convention, sixty architects told hospital administrators where to get on. Following a talk by William A. Riley of Boston, every architect in the room said he would like to have a written program for each job, carefully developed by the administrator in consultation with the heads of important hospital departments. Not a single architect present, however, had ever received such a written program, it was reported—more in sorrow than in anger.

New building materials, revision of obsolete building codes and design changes may offer some promise of economies in hospital building, Robert Cutler of Skidmore, Owings & Merrill predicted. "You can cut costs right now," added Isadore Rosenfield of New York, "by planning fewer private rooms." Whatever it costs to build, warned T. Joseph Hogan of the U.S. Public Health Service, beware of penny-wise economies that may result in higher operating costs.

Under P.L. 725, Some 400 Projects Approved

WASHINGTON, D.C.—In a report issued last month, the Division of Hospital Facilities, U.S. Public Health Service, stated that a total of 405 project applications had been approved by the surgeon general under Public Law 725 providing for the construction of hospitals and health centers.

Estimated total cost of the projects was $195,466,253, the report said, of which $57,299,166 is the estimated federal share.

Three hundred eight of the 405 projects have initial applications only approved, the remainder are completed applications, it was stated.

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NEWS...

Council Analyzes N.Y. Beds in Light of Long-Term Planning

NEW YORK. — Hospital buildings in New York City are considered in the light of their usefulness over a future period of years in a bulletin issued last month by the Hospital Council of Greater New York. The most frequent reason for classifying a building as unsuitable for planning on a long-term basis was that it was of nonfire-resistive construction, the report stated.

"The age of hospital buildings alone is an important factor in New York City," it was stated. "There are twenty-eight general care hospitals with all or part of their beds in plants built of fire-resistive construction which are over 35 years old. The majority of these buildings, because they are substantially constructed, have been classified as suitable for planning over a period of years. It is obvious that their useful life will be limited by their very lack of flexibility.

"On the other hand," the council pointed out, "there are many hospitals in which the beds are in modern up-to-date buildings, while the laboratories, laundries, outpatient department, and other services are housed in old structures. The result is that an evaluation of the hospital's beds in relation to the need does not always give a complete picture of the expansion and replacement requirements of the hospitals."

MANY NOT ACCEPTABLE

More than one-fifth of all the general hospital beds in New York City are in plants that are unacceptable for long-range planning, it was stated. "Present building costs are in the neighborhood of $20,000 per bed," the council said. "This means that the money required to catch up with the backlog of replacement and expansion of general care facilities needed by 1950 will total almost $170,360,000."

The report concluded: "The expenditure of such a large sum of money calls for a careful evaluation of all proposed new hospitals. When hospital buildings reach the end of their useful life, they should be replaced in accordance with the needs of the community. It is hoped that those in authority will make it possible for these facilities to be rebuilt—not necessarily at their present sites, but in sections of the city which urgently need hospitals."

Announcement was made in the bulletin of the designation of Presbyterian Hospital, Wyckoff Heights Hospital, and Norwegian Lutheran Hospital as participating hospitals in the council's program.

A.M.A. Council Opposes Blue Cross-Blue Shield Prepayment Combine

CHICAGO.—Organization of the proposed Blue Cross-Blue Shield Association as approved by the house of delegates of the American Hospital Association at Atlantic City last month ran into difficulties here when the council on medical service of the American Medical Association issued a confidential memorandum objecting to the proposals.

Disapproval by the council does not legally restrain the Blue Shield commission from going forward with formation of the association, observers pointed out, but it might keep individual plans from participating until the A.M.A. house of delegates has expressed itself on the proposals.

In its memorandum, the council on medical service stated that Associated Medical Care Plans, Inc. (Blue Shield) "was never intended as a policy making body" but was intended rather "to serve as a trade organization interested in the technicalities and problems of prepayment, in the coordination of plans, in the development of technics, and in obtaining actuarial data."

The council also objected that the board of governors might take control of the proposed insurance plan out of the hands of medical members. "Hospital members [of the board of governors] are mostly laymen," the memorandum said. "Therefore, according to the organizational plan, the majority of the board of governors of this organization may be nonmedical individuals."

Since the proposed organization structure has been published, the memorandum stated, the council has received "many unsolicited letters and telegrams disapproving the formation of an A.M.C.P.-Blue Cross insurance company."

"The council would like to know more as to what is back of this insurance company idea. . . . This follows the pattern which has been used to bring about the socialization of medicine in several European countries," the council's statement said.

Graham Davis Attacks Brown Report on "Nursing for the Future"

CHICAGO.—In his final appearance as president of the American Hospital Association, Graham Davis of Battle Creek, Mich., told the association convention in Atlantic City September 23 that Dr. Esther Lucille Brown's report, "Nursing for the Future," ignores the facts of life.

"Nurses twenty years from now will not look back with pride on this period in their history," Mr. Davis said, referring to what he termed the "trade unionism element" in nursing. "There was a better way to seek economic security," he declared.

Mr. Davis, who pointed out that Dr. Brown was not a nurse and that the survey on which the report was based covered a comparatively small number of nursing schools, was especially critical of her characterization of many small hospital schools of nursing as "socially undesirable." He defended these schools, pointing out that they made it possible for hospitals to deliver nursing service throughout the war and postwar shortages. Mr. Davis praised especially the nurses who stayed at home on hospital duty during the war.

The Brown report was described as "constructive thought" in an editorial appearing in the *New York Times* September 29. Summarizing Dr. Brown's findings on the number of nurses needed in the field, the editorial said: "As against these needs, nursing has been fighting a losing battle in attracting the needed number of young women; a variety of occupations and professions beckon to them, often offering better salaries and working conditions.

"The report concedes that nursing, with its opportunities for helping others, has a deep intrinsic appeal but holds that if enough young women are to be attracted to this service it must be supported, among other things, by better pay and more stable working conditions. Solution of the immediate emergency is seen as requiring more careful functional organization of nursing service, with many of the less complex duties carried by trained practical nurses and assistants working under supervision. The formula for correcting the nursing shortage recommended in 'Nursing for the Future' should be studied in seeking to find a solution for the broad problem," the *New York Times* editorial concluded.

NEWS...

Hayt Sees Flaws in California Ruling on Salaried Doctors

NEW YORK.—The recent opinion by the attorney general of California that hospitals employing physicians on salary may be engaging illegally in the practice of medicine overlooks the fundamental differences between nonprofit and proprietary hospitals, Emanuel Hayt, New York medico-legal authority, stated in reply to an inquiry from The MODERN HOSPITAL.

Mr. Hayt's article, "Legal Aspects of Specialists' Contracts," which appeared in The MODERN HOSPITAL for May 1948, was winner of the Gold Medal Award for the best article appearing in the magazine during the period July 1947 to June 1948.

Mr. Hayt's statement on the California attorney general's opinion follows: "The basic fault with the opinion is that the attorney general overlooks the fundamental differences between nonprofit and for-profit hospitals, as is evidenced toward the end by the revealing statement: 'Throughout the opinions cited one will note that the courts have indicated that the practice of medicine by corporations for profit, through the employment of licensed physicians, has a tendency to debase the profession, is not in the interests of the public, and therefore is contrary to public policy.'

"The case of People *v.* Pacific Health Corp., supra., decided by the Supreme Court of California, Sept. 2, 1938, and cited by the attorney general, holds that a stock corporation operated for profit may not select the hospital or doctor to treat a subscriber to a policy of health insurance. In quoting the court's declaration that a corporation may not engage in the practice of medicine, the attorney general ignores the following significant language which distinguishes the defendant corporation from nonprofit corporations:

" 'We are told that a decision against defendant will outlaw all fraternal, religious, hospital, labor and similar benevolent organizations furnishing medical services to members. We have given careful consideration to this argument and we find it wholly unconvincing.

" 'In almost every case the institution is organized as a nonprofit corporation or association. Such activities are not comparable to those of private corporations operated for profit and since the principal evils attendant upon corporate practice of medicine spring from the conflict between the professional standards and obligations of the doctors and the profit motive of the corporation employer, it may well be concluded that the objections of policy do not apply to nonprofit institutions. This view almost seems implicit in the decisions of the courts and it certainly has been the assumption of the public authorities, which have, as far as we are advised, never molested these organizations.'

"The only logical explanation for this confusion is that the attorney general regards a for-profit corporation as one which charges more than cost for its services, hence it is operated 'for profit.' Conversely, if it charges cost or less, it is a 'nonprofit' corporation. This distinction is incorrect: it is the nature of the incorporation rather than whether or not it makes a profit on any of its services that controls. As held in the case of Scripps Memorial Hospital *v.*

NEWS...

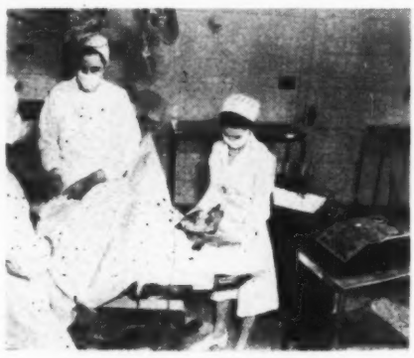
California Employment Commission, 151 P. 2d 109, the fact that the services of the hospital yield some profit is negligible if financial gain is not the purpose of the service."

Preoperative Patients Hear Recorded Music

DAYTON, OHIO.—Music is helping to soothe nervous and anxious patients awaiting operations at St. Elizabeth Hospital here, according to a recent report from the hospital.

This unusual therapy is being done through the use of a wire recorder, it was explained. Several other hospitals in the country have reported experiments with wire recorded music for pre-operative patients.

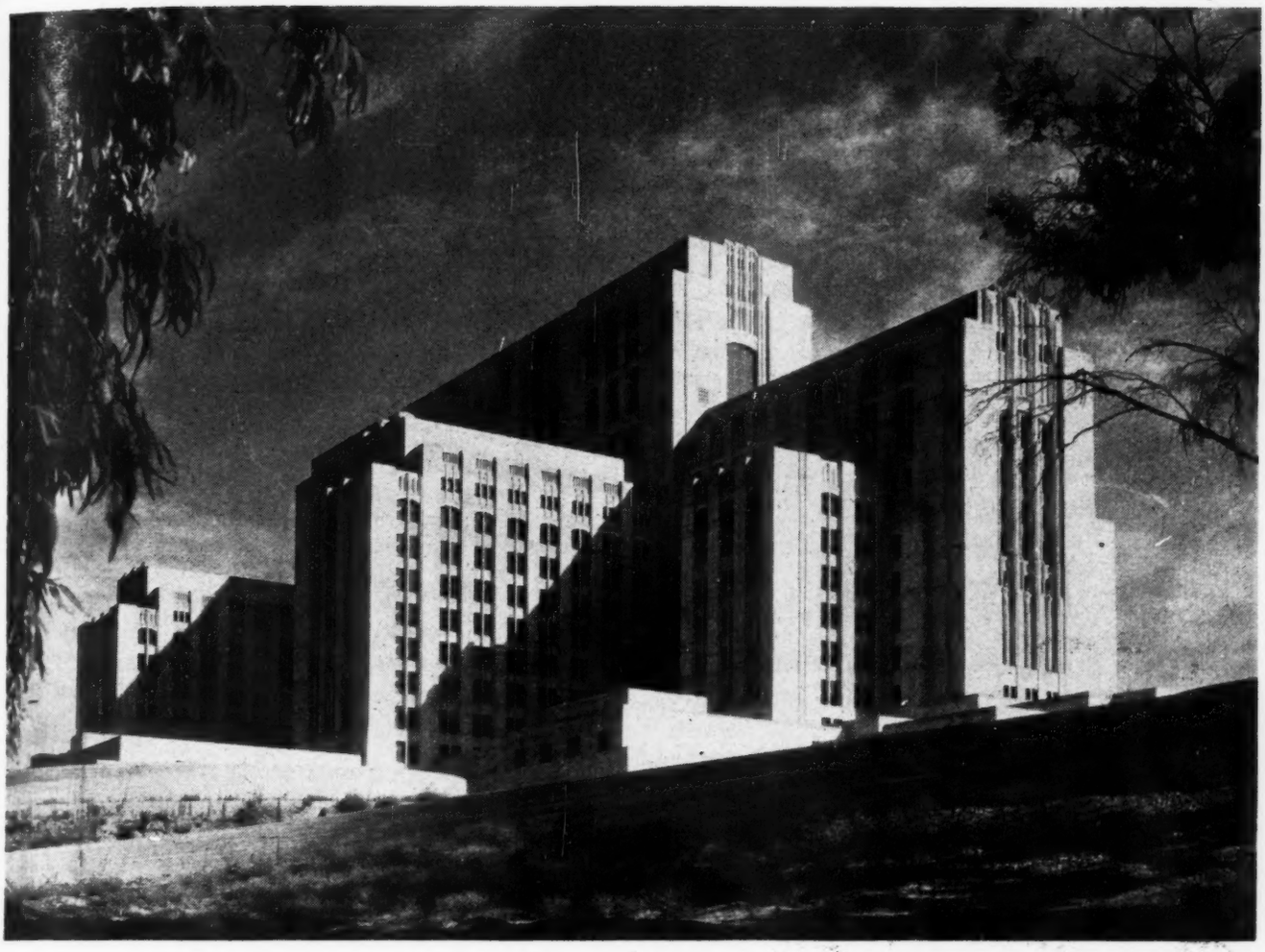
The wire recorder, operated by the anesthetist, is used only when local anesthetics are administered or in the moments before a general anesthetic is used. Because of the high volatile gases used in general anesthetics, the electrical wire recorder must be then disconnected. The anesthetist records all her own music, most of it at her own home. To date she has several spools of wire, each containing forty-five minutes of tunes and stories.



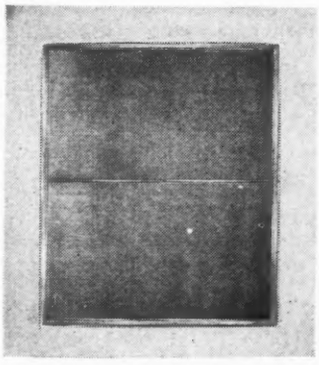
Wire recorder soothes patients.

One of the anesthetists reports, "I place the earphones (which resemble a small stethoscope) into their ears as soon as they are transfered to the operating table. The effect is miraculous. Patients tense with fear of the approaching surgery relax almost instantly. Many of them go to sleep—even with the local anesthetic—with the pleasant strains of a waltz ringing in their ears."

Sometimes after the patient has fallen asleep during the operation, the anesthetist switches the music from the earphones to a loud-speaker contained in the machine, so that all in the operating room may hear the music.



CECO HELPS A MONUMENT OF MERCY BREATHE...



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One of the truly important details in a hospital is ventilation, and that, in a sense, is where Ceco helped beautiful Los Angeles County Hospital to breathe. Ceco installed the metal frame screens which, of course, provided a means of ventilation. This was done at a saving, too, because Ceco screens cost less than ordinary screens—they are factory finished, eliminating on-the-job painting, trimming and fitting. They are easy to put up and take down—will not warp, shrink, twist or rot.

Other Ceco Products used in the Los Angeles County Hospital were steel bars and welded wire fabric which provide a positive bond and add strength in reinforced concrete construction.

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NEWS...

Medical Progress Will Depend on University Medical Center, Says Dean

CHICAGO.—Medical progress of the future will increasingly depend on the university medical center, composed of the medical school, affiliated hospitals, and all the other scientific resources of the university, Dr. J. Roscoe Miller, dean of the Northwestern University Medical School and recently named president of the university, stated last month in an address to a conference of the boards of directors of Jewish charities of Chicago, New York, and Philadelphia.

The practice of completely isolated research has been largely succeeded by the more efficient one in which the work of chemists and physicists, even of anthropologists, zoologists and engineers, is coordinated with the research of medical men in laboratories and clinics in the constant battle against disease, Dr. Miller pointed out.

It is upon this interdependence of pure and medical science that the structure of modern medicine is built and will grow, Dr. Miller declared.

"Instances have come to our attention in the last two decades which emphasize that so-called 'useless' research has suddenly become of paramount importance to medicine. Research that is done by a chemist in the dye industry may turn out to be of vast significance to the healing arts, as witness the sulfonamides. Ivory tower research may lead to avenues where the results, in terms of human welfare, can be weighed and measured."

The importance of university medical centers has been shown by their cooperation with the Veterans Administration in caring for ill and wounded former servicemen, Dr. Miller continued. The first such cooperative organization was developed at Chicago, he said, with Hines and Vaughan hospitals calling upon the resources and faculties of the medical schools of Northwestern University and the University of Illinois.

"The programs in basic science, augmenting the training in the specialties, at the two universities have been incorporated in the curriculum at the veterans' hospital, so that there is an interchange between the facilities of the medical schools, their laboratories, and their affiliated hospitals and those at the government agency," Dr. Miller explained.

Under the university-V.A. setup, the average stay of the patient in the hospital has been cut almost in half, Dr. Miller said, and the veteran has been given access to the best medical care which the two teaching institutions could offer.

"There has been an enormous saving to the taxpayer, and medical research has been carried out as never before in a government agency. What is also important is that the general tenor of the medical corps has reached a new high."

Dr. Miller described Northwestern's long-term plans for an expanded medical center on its Chicago campus. Several new hospitals and the comprehensive Institute for Medical Research are projected as additions to Northwestern's present affiliates, Wesley and Passavant hospitals, and its off-campus affiliates, Children's Memorial and Evanston hospitals. First among the new hospitals on the Chicago campus will be a Veterans Administration building, to have 600 beds, 200 of them devoted to tumor

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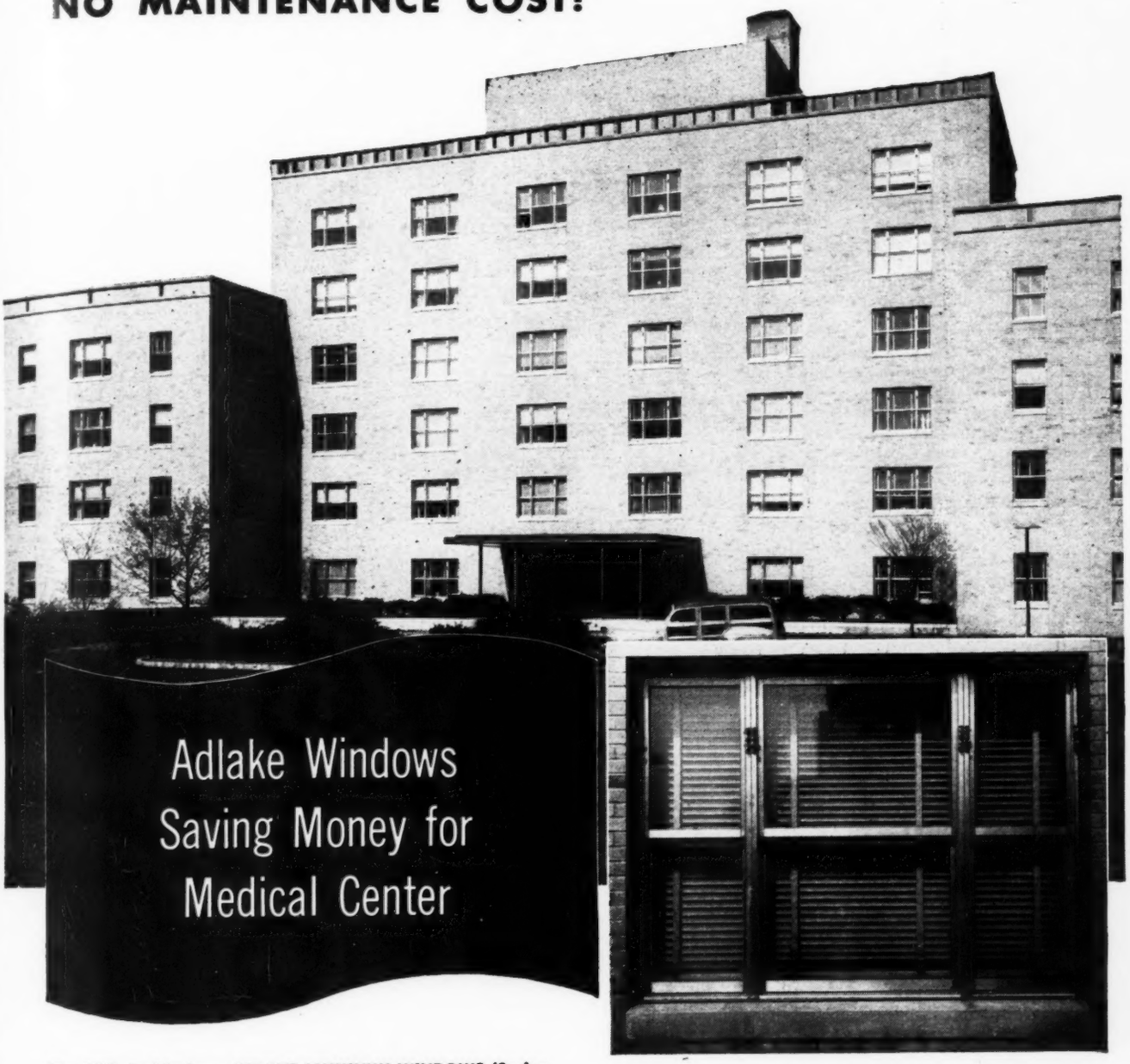

Adlake Windows Saving Money for Medical Center

The 937 double-hung ADLAKE ALUMINUM WINDOWS (Series 600) in the newly-built Edward S. Harkness Memorial Hall,* at Columbia Presbyterian Medical Center, New York City, will save the Center a considerable sum, over a period of years, through *eliminating* maintenance costs. The windows will ultimately *pay for themselves* through this economy. Adlake Windows require no painting, no maintenance other than routine washing! And they *last as long as the building.*

ONLY ADLAKE WINDOWS have the combination of woven-pile weather stripping and patented serrated guides that assures minimum air infiltration and absolute finger-tip control.

Adlake Windows never warp, rot, rattle, stick or swell. They look lovely and operate smoothly for the life of the building.

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Exterior view of Series 600 Window in Harkness Hall shows trim appearance and polished beauty that Adlake Aluminum Windows impart to any building, new or remodeled.

**Architects: Voorhees, Walker, Foley & Smith; Contractor: Vermilya-Brown.*

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MEMBER, ALUMINUM WINDOW MANUFACTURERS ASSOCIATION

NEWS...

cases, and 22,000 square feet of space allocated to research.

For the furtherance of research, the plans also contemplate coordination with the medical school of all the scientific resources of the university, including the school of dentistry, the program in hospital administration, the technological institute and the school of speech, whose experts in hearing and speech defects are linking their research with that of medical specialists.

Purchasing and Accounting Institutes in November

CHICAGO.—Two institutes for hospital administrators and departmental personnel will be conducted by the American Hospital Association during November, according to an association announcement. These are an institute on hospital purchasing, November 1 to 5, in Boston, and an institute on advanced accounting, November 15 to 19 in Long Beach, Calif.

Planned to help students from all hospitals develop sound purchasing knowledge and practices, the institute on hospital purchasing will be of particular interest to those who cannot devote full time to purchasing duties. The organization of purchasing and receiving departments in relationship to other departments, purchasing practices, legal aspects, and specific product purchasing will be included in the program, it was explained.

Jointly sponsored by the Massachusetts Hospital Association and the Boston Hospital Council, the institute's faculty will be comprised of such expert speakers as Donald L. Reams, general manager of the hospital purchasing service in Philadelphia, and Warren W. Irwin, general purchasing agent of the University of Rochester. Richard O. West, director of Salem Hospital, Salem, Mass., is chairman of the local committee.

The last accounting institute to be held in 1948 will furnish hospital administrators, accountants and other personnel with important knowledge of the best accounting practices vital to hospitals' economic well-being, the announcement stated. The institute faculty includes Charles G. Roswell, chairman of the American Hospital Association's committee on accounting and statistics. Co-sponsor is the Association of Western Hospitals.

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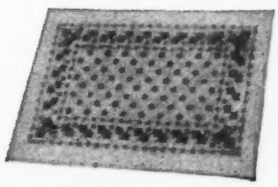
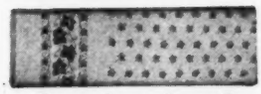

tray cloths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NEWS...

Specific Problem Solving Features Personnel Institute

NEW YORK. — Departures from the usual hospital institute classroom procedure featured the American Hospital Association's personnel relations institute here October 4 to 8.

Instead of relying solely on lectures and discussion of general hospital personnel problems, the institute provided an opportunity for those attending to pool their knowledge and experiences, under competent direction, in the analysis and solution of personnel problems, association officials said. The aim was to help each member to become more capable of understanding and working out satisfactory solutions to problems in his own hospital.

Recognizing that department heads and supervisors, as well as administrators, represent hospital management to the employe, the program sought to help these people as well as personnel directors to become more effective members of the management team.

Morning sessions treated five important functions of personnel administration: (1) objectives of personnel administration, (2) policy, (3) training, (4) salary and wage administration, and (5) communications.

The fifteen outstanding leaders from hospital management, industry, colleges and universities who discussed these topics then served as consultants in afternoon sessions, in which each student had an opportunity to discuss and analyze the personnel administration problems in his own hospital. The groups diagnosed and sought remedial action for solving these specific problems.

N.Y. Hospital Council Names New Members

NEW YORK.—Norman S. Goetz, president of the Hospital Council of Greater New York, recently announced the election of five new members to the board of directors of the council.

Elected for a three-year term by representatives from the council's member organizations, the new board members are: James W. Husted, Dr. Howard A. Rusk, Winifred Fisher, Nathan S. Sachs, and T. J. Ross. Members reelected to the board for a three-year term are: Arthur A. Ballantine, Dr. Jean A. Curran, Dr. Haven Emerson, Dr. Morris Hinenburg, and Raymond P. Sloan.

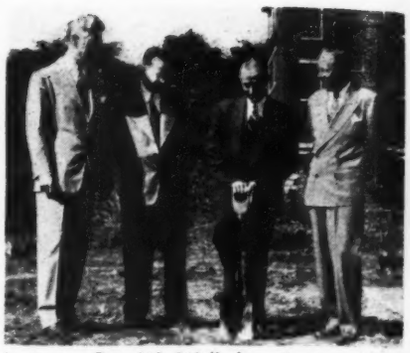
NEWS...

Evanston Hospital Starts First of Three Additions

EVANSTON, ILL.—Ground was broken here October 1 for a major addition to Evanston Hospital, the first of three additions planned in the hospital's expansion program, Dr. Roger W. DeBusk, hospital administrator, announced.

In a statement pointing out that the urgent need for added space led to the decision to start construction of the new building, Robert T. Sherman, president of the hospital board, said:

"The campaign for funds for the needed expansion of facilities has reached the point at which actual construction of the first of the three new buildings can be started. There remains an urgent need for the other facilities called for in the program. These will cost about $5,000,000, which must come from public-spirited members of the community."



L. to r.: Roy W. Walholm, vice president; Dr. R. W. DeBusk, executive director; Robert T. Sherman, president, and Dr. Sam Lang, medical staff president.

Plans for the additions are based on comprehensive study of the needs of the entire north suburban area, Dr. DeBusk explained. The project started October 1 comprises a six-story addition to the west end of the present main building and a two-story connection with the Abbott Memorial laboratory.

The new building will add 92 beds to the hospital's total, bringing it to 338. The added beds will be divided between private rooms, two-bed and four-bed wards, Dr. DeBusk said.

Included in the new structure will be a large x-ray department, added operating rooms, increased office facilities for doctors, many service rooms, enlarged quarters for the auxiliary shop, and a snack bar for visitors and the staff.

The second unit in the complete expansion program will be a maternity building. The third project will include facilities for psychiatric care and tuberculosis, a pediatrics division, a dental clinic, and a tumor clinic in connection with the outpatient department. Also needed will be increased service facilities, such as added power plant and an enlarged laundry.

Architects of the new building are Schmidt, Garden and Erikson, and construction contractor is R. C. Wieboldt Co.

To Build Dental Clinic

WASHINGTON, D.C.—The Group Health Association will build a $500,000 medical and dental clinic here, according to an announcement September 4. The new building will be financed by the sale of investment certificates to members of the association. The facilities will take care of a membership expected to grow to 30,000 in the next few years.

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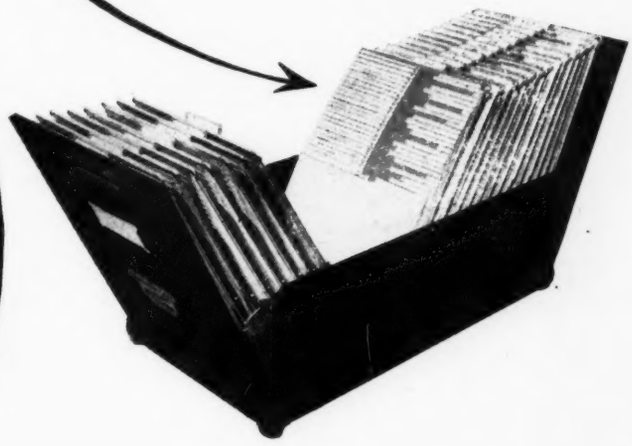

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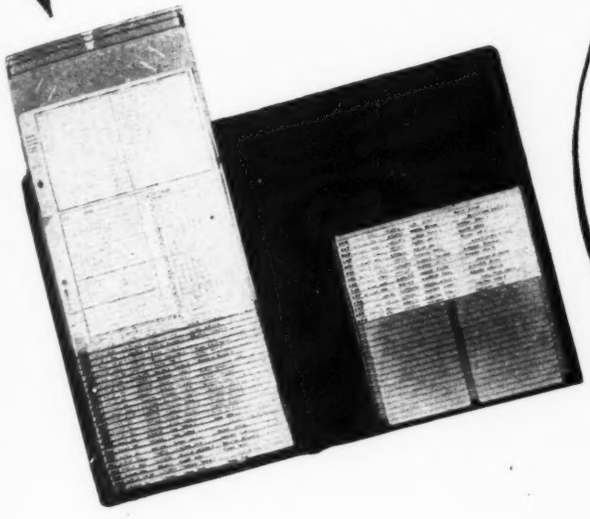

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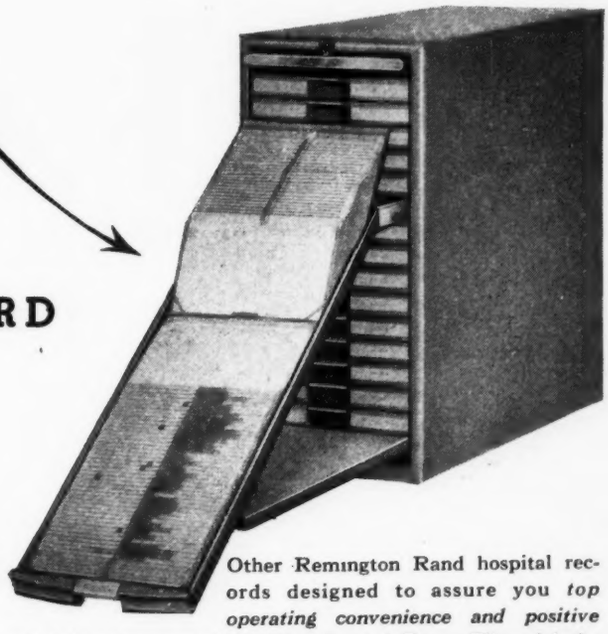

PERSONNEL RECORD

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NEWS...

European Hospitals Studied for Ideas in Construction

WASHINGTON, D.C.—Gilbert S. Underwood, supervising architect of the Public Buildings Administration, F.W.A., is making an intensive study of hospitals and medical installations in Europe.

His itinerary covers Europe from Rome in the South to Helsinki in the East to Dublin in the West. His inspection of hospitals embraces ten countries and thirty cities.

The Public Buildings Administration is in charge of the design and construction of the new District of Columbia Medical Center and of the research hospital for the National Institutes of Health at Bethesda. Maj. Gen. Philip B. Fleming, Federal Works Administrator, has asked W. E. Reynolds, commissioner of P.B.A., to spare no effort in the study of medical and hospital installation technics in order to make these projects the most modern of hospital buildings.

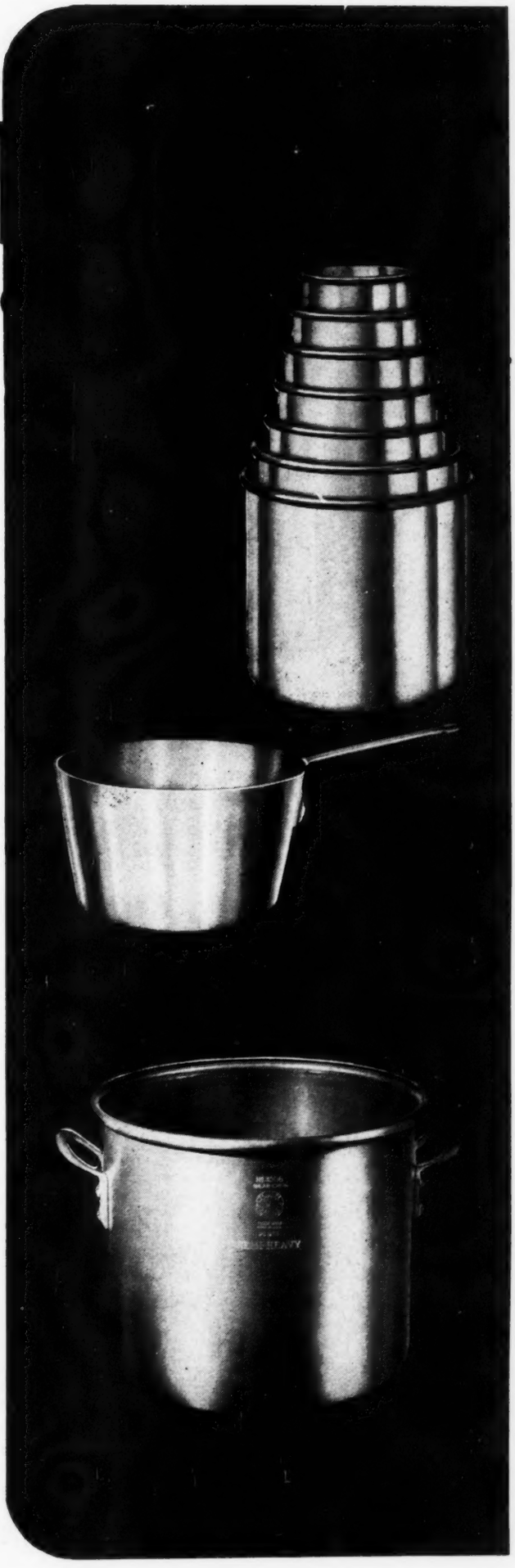
Close attention is being paid by Mr. Underwood to the more recent developments in hospital construction in the Nordic countries, particularly Sweden. The South Hospital in Stockholm, one of the largest in the world, approximates in size the proposed District of Columbia Medical Center. P.B.A.'s hospital planning staff has already visited most of the outstanding hospitals in this country.

The Public Buildings Administration also designs and constructs marine hospitals for the U.S. Public Health Service. P.B.A.'s current projects in this area cover: the thirteen-story brick building which will house the National Institute of Mental Health and hospital facilities of the National Cancer Institute, the National Heart Institute and the National Institute of Dental Research; and the 1250 bed District of Columbia Hospital Center. The latter embraces three of Washington's hospitals—Emergency, Garfield and Episcopal Eye, Ear, Nose and Throat.

100 Bed Addition Opened

JANESVILLE, WIS.—A new building providing 100 additional beds was opened at the Mercy Hospital here last month, Sister Cor Marie, superintendent of the hospital, announced. The addition cost $750,000.

ECONOMY T
FOR YOUR KIT



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Wear-Ever semi-heavy duty utensils combine lower initial cost with ease of handling and long lasting durability. For further details see your supply house representative or write to:

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NEWS...

Results Surpising in Mass TB Survey

CHICAGO.—More than 5000 cases of unsuspected tuberculosis were found in the mass tuberculosis chest survey carried out in Washington, D.C., from January 12 to July 1, Dr. Arthur C. Christie told the American Roentgen Ray Society in its convention here last month.

"A significant fact disclosed by the Washington survey," Dr. Christie said, "is the relation of the total number of cases of tuberculosis disclosed by the survey to the cases registered at the Washington Health Department as tuberculosis. Of the more than 6000 cases, only 567 were on the tuberculosis registry, leaving about 5600 cases previously unknown to the health department, of which from 83 to 85 per cent are in a minimal stage and about 10 per cent only moderately advanced."

Dr. Christie said that a total of 503,398 persons was examined in the survey, but that a complete analysis of the results will not be available for several months.

In discussing the value of such a survey, the largest ever made, Dr. Christie said: "The question has been raised frequently as to the practical value of the mass survey method, which requires the examination of such a large number of nontuberculous individuals to screen out a relatively small percentage of cases of tuberculosis. There seems to be little doubt of the value of a method which discloses more than 5000 people in a city the size of Washington who have tuberculosis, previously unknown, the great majority of them at an early stage of the disease.

"It is true that examination of selected groups of the population in which the incidence of tuberculosis is known to be high will yield much higher percentages of positive cases.

"The practice of examining the chest of all patients who are admitted to general hospitals is proving a fruitful case-finding method, and very recently reports have been made of the high incidence of tuberculosis among the patients who seek the advice of general practitioners.

"Any method that discloses cases of tuberculosis is valuable and should be used wherever practicable. There is little doubt, however, that the final control of tuberculosis will depend upon well organized, systematic mass surveys supplemented by persistent examination of selected groups in which the incidence is known to be high.

"The aspect of the problem which needs the greatest emphasis at the present time is the follow-up, management and treatment of the individual patient once the disease is discovered. It must be increasingly appreciated that the finding of the case is only the beginning of a mass survey."

Dedicate X-Ray Laboratory

MILWAUKEE. — Intensification of x-ray images by electronic means may usher in a new era in x-ray diagnosis, Dr. William D. Coolidge stated in an address here last month. Dr. Coolidge outlined many developments in x-ray and related sciences that are promised by research already underway. As director emeritus of the General Electric Research Laboratory at Schenectady, N.Y., he spoke at dedication ceremonies opening a new research laboratory here.

NEWS...

Group Hospitalization, Inc., to Boost Rates Nov. 1

WASHINGTON, D.C.—Beginning November 1, Group Hospitalization, Incorporated, is increasing its charges to subscribers to help offset rising hospital costs. G.H.I.'s President Joseph W. Himes announces greater benefits along with the boost in rates, one being a new service contract providing for thirty days' hospitalization instead of the twenty-one days' now allowed.

All of the 375,000 Washington subscribers are affected by the increased rates. Not affected are the 83,000 subscribers of the prepayment surgical plan, operated in conjunction with the District Medical Society.

The new schedule of monthly rates increases are from 65 cents to $1.10 for individuals; from $1.50 to $2.50 for husband and wife, and from $1.75 to $2.75 for family contracts. Present contracts cover costs to subscribers of semiprivate rooms, meals and special diets, routine nursing care and laboratory examinations, drugs, medicines, surgical dressings, and use of operating and delivery rooms.

Expanded service under the new rates will include:

Thirty days of hospitalization instead of the twenty-one days formerly granted.

Discounts on the semiprivate room charges beyond the thirty-day limit will be increased from 10 per cent to 50 per cent up to an additional 180 days in participating hospitals.

Payment of $15 for the first day and $6.50 a day thereafter up to thirty days for subscribers hospitalized in out-of-town hospitals.

Hospitalization up to ten days for pulmonary tuberculosis, poliomyelitis, mental or nervous disorders, alcoholism, drug addiction, and quarantinable diseases.

Payment for oxygen therapy, intravenous injections and solutions, and all serums except blood and blood plasma.

An allowance up to $10 for emergency hospital treatment when the subscriber does not have to become a bed patient.

Some 40 per cent of the beds in seventeen hospitals participating here in the plan are occupied by G.H.I. patients. Several months ago the hospital council listed among major causes of the hospital financial crisis inadequate G.H.I. payments. Mr. Himes said it was only right that the hospitals should look to G.H.I. to do its share in meeting higher costs resulting from the inflationary trend of the times.

Philadelphia Continues Practical Nurse Courses

PHILADELPHIA.—The fourth class of practical nurses was enrolled last month in the training course sponsored cooperatively by the Philadelphia public schools and a group of voluntary hospitals here, according to hospital council announcement.

Fifty-five women have been graduated from the course so far, the announcement said, and the first group completed nine months of hospital in-service training October 1.

Hospitals participating in the program are Hahnemann, Mount Sinai, Philadelphia General, St. Luke's, Children's, Temple University, and the Home for Incurables.

NEWS...

Can Still Apply for Army Civilian Internships

WASHINGTON, D.C.—Medical school graduates will have until November 1 to apply for commissions under the Civilian Resident and Civilian Intern Training Programs of the army medical corps.

This graduate training was instituted by General Bliss with the advice and help of the American Medical Association, the Society of Consultants of World War II, and other medical organizations to help bring army medicine into closer contact with civilian medicine.

Under the program selected individuals serve out their internships and residencies in civilian hospitals of their choice. Interns are commissioned as first lieutenants of the medical corps reserve; residents, as first lieutenants in the regular army medical corps. Both receive full pay and allowances of their rank, plus $100 a month professional volunteer bonus. Both complete their training just as they would as civilians.

Upon completion of their year's training, interns must apply for regular commissions and may qualify for residency training. Residents may continue their residency training upon concurrence of the hospital with a view to qualifying for specialty courses leading to certification by American Specialty Boards. Here the graduate training program meets the career management program under which medical officers are assured of continuation in their chosen specialties during army service unless they choose administrative or staff careers.

Officers who participate in these programs are expected to serve a year of active duty for each year of training they receive.

Seek Two Million to Fight Arthritis

WASHINGTON, D.C.—A national campaign to raise $2,000,000 to fight arthritic and rheumatic diseases was announced here September 15. Dr. W. Paul Holbrook of Tucson, Ariz., president of the recently established Arthritis and Rheumatism Foundation, said that the money will be used to set up research, education and treatment facilities for rheumatic ailments from which 7,000,000 persons are suffering. A wide research program will be developed with the aid of the National Research Council.

NEWS...

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Elks Club, Los Angeles, Oct. 18-22. Regular Course, Los Angeles, Oct 25-29.

AMERICAN COLLEGE OF SURGEONS, Hospital Standardization Conference, Biltmore Hotel, Los Angeles, Oct. 18-22.

AMERICAN DIETETIC ASSOCIATION, Hotel Statler, Boston, Oct. 18-22.

AMERICAN PUBLIC HEALTH ASSOCIATION, Boston, Nov. 8-12.

ASSOCIATION OF CALIFORNIA HOSPITALS, Santa Barbara, Nov. 11-12.

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Nov. 19-20.

MARYLAND-DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, Statler Hotel, Washington, D. C., Nov. 8-9.

MICHIGAN HOSPITAL ASSOCIATION, Pantlind Hotel, Grand Rapids, Nov. 8-9.

MISSISSIPPI HOSPITAL ASSOCIATION, Buena Vista Hotel, Biloxi, Oct. 18-19.

MISSOURI HOSPITAL ASSOCIATION, Jefferson Hotel, St. Louis, Dec. 6-7.

MONTANA HOSPITAL ASSOCIATION, Placer Hotel, Helena, Oct. 18-19.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 17, 18.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 4-5.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Nov. 1-3.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Charles Gurney Hotel, Yankton, Oct. 18-19.

1949

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago, Feb. 4-5.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, May 9-12.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Asheville, N.C., April 21-22.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 18-20.

MID-WEST HOSPITAL ASSOCIATION, Kansas City, April 26-28.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, Mass., Mar. 28-30.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, Ohio, March 23-26.

SOUTHEASTERN HOSPITAL CONFERENCE, Buena Vista Hotel, Biloxi, Miss., April 27-29.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, April 19-21.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 26-28.

Institute for Sisters of Mercy

CHICAGO.—One hundred and forty Sisters who are administrators and nursing directors at hospitals operated by the Sisters of Mercy attended an institute at Mercy Hospital here September 11 to 14. Joint sponsors of the institute were the Catholic Hospital Association, American College of Hospital Administrators and American College of Surgeons. Subjects covered in lectures and discussions included all aspects of hospital administration and nursing services.

NEWS...

A.H.A. Approves New Red Cross Aide Program

WASHINGTON, D.C.—The board of trustees of the American Hospital Association has approved a resolution of its council on professional practice recommending endorsement of the reactivation of the American Red Cross program for the training of volunteer nurse's aides, it was announced here.

The resolution states: "Whereas, a relative shortage of available personnel for professional and subsidiary workers in nursing service continues to exist; and whereas, there is a continuing need as shown by an increasing number of requests for the services of nurse's aides; and whereas, even when hospitals are fully staffed with both professional and subsidiary workers, volunteer nurse's aides may be utilized in emergencies, in periods of special demand to avoid overloading of professional personnel, and for extra services which contribute to the comfort and care of patients but may not be provided as a part of basic essential nursing service; and whereas, a carefully trained and selected volunteer group provides an excellent means of interpreting hospital needs and problems to the community; therefore be it resolved, that the council on professional practice recommend to the coordinating committee and the board of trustees that the American Hospital Association endorse the reactivation of the American Red Cross program for training of volunteer nurse's aides; and that the recruitment and training of volunteer nurse's aides be initiated by local determination through the implementation of a local committee including professional members of local hospital groups, nursing associations, and public health agencies."

Red Cross volunteer nurse's aides receive an eighty-hour training course given by an authorized registered nurse instructor, it was explained. They then assist in meeting community needs by working as assistants to graduate nurses in wards of civilian and federal hospitals; in outpatient departments and accident rooms; in hospital, health and industrial clinics, and in public health nursing agencies by: taking temperature, pulse, respiration; giving morning and evening care; preparing and setting up treatment trays for sterilization; assisting with unsterile dressings; helping apply casts, and assisting in emergency rooms.

They are prepared to assist in the foregoing and similar duties in disaster relief operations, in blood centers, and, after additional training, in convalescent care of poliomyelitis patients.

Congress on Physical Medicine Held Last Month

WASHINGTON, D.C.—The American Congress of Physical Medicine held its 26th annual scientific and clinical session here in week-long meetings beginning September 8. Reports were made on the latest developments in the treatment of disease, including the use of atomic energy, radar and sonar.

Some 500 to 700 physicians, nurses and technicians from all over the United States participated. Among other things, the congress heard fifty-seven papers on disease treatment by physical agents such as heat, light, exercise and massage, on adopting atomic and other types of energy for therapeutic purposes, and on such subjects as rehabilitation, cerebral palsy, and poliomyelitis.

NEWS...

Polio Care in General Hospital Urged in Report

NEW YORK.—"The general hospital is the ideal place to care for the poliomyelitis patient; it offers all the various medical services and hospital facilities that are essential for the complete care of the patient, without hazard of infection to other patients or to hospital personnel," it was pointed out last month in the *Bulletin* of the Hospital Council of Greater New York.

While statistics show that the incidence of infantile paralysis has been climbing upward during the last five years, it remains numerically an infrequent disease, the council continued. "Because polio hits suddenly, in widely separated areas—one year here, the following year there—and because in the public mind it is one of the most dreaded diseases," the *Bulletin* stated, "the general hospital which prepares to offer adequate care to the patient with polio is offering an additional service to the community. In turn, this additional service will make the community more than ever aware of the value of its general hospital."

The council cited the unit for patients with poliomyelitis at Knickerbocker Hospital in New York City as the type of service that might serve as an example to general hospitals wishing to offer this additional community service. "The general hospital that anticipates offering the community services essential to polio patients probably will want to evaluate its program in advance of the usual polio season," it was pointed out. "In such an evaluation, three basic requirements should be considered," the council continued. "These are bed facilities, equipment and trained personnel."

It is not necessary or advisable for the hospital to establish a costly permanent unit for these patients, it was explained. If the general hospital is planned and operated in a flexible manner, its facilities can be utilized to the limit, when and if the need arises, the *Bulletin* said.

"Most, if not all, general hospitals have an opportunity now to prepare for emergencies in this field," the report concluded. "There is slight cost involved, for additional beds seldom are needed, equipment is available through the National Foundation for Infantile Paralysis, and the training of personnel also is made easier through suitable professional and official channels. Results of such preparation may not be felt for several years, but when an epidemic does strike the hospitals will be in a far better position to perform a community service that will save lives and make friends."

Campaign Head Named by United Hospital Fund

NEW YORK.—Henry M. Stevens, vice president and director of the J. Walter Thompson Company, has been appointed general chairman of the 70th annual campaign of the United Hospital Fund, it was announced last month by Roy E. Larsen, president of the fund.

Mr. Larsen said that the new chairman would take over his duties immediately, directing the activities of the city-wide organization of volunteer workers whose sole aim within the next two months will be to raise several million dollars to meet the aggregate operating deficits of the fund's eighty-six New York voluntary hospitals.

NEWS...

Lohr Urges Formation of General Practice Sections on Hospital Medical Staffs

KANSAS CITY, MO.—The formation of general practice sections on hospital medical staffs was strongly urged by Dr. Curtis H. Lohr, superintendent of St. Louis County Hospitals, Clayton, Mo., in an article which appeared last month in the *General Practice News* published here by the American Academy of General Practice. Dr. Lohr recommended that these sections be organized following amendment of staff rules and regulations "to define the scope of the section's activities, its relation to the staff as a whole and to the specialty sections in particular."

Staff rules should also define the standards of service to be rendered by members of the general practice section, requirements for consultation, clinical records and all other regular staff activities, it was stated. Rules should also include "specific provisions concerning the eligibility of the members of the general practice section to engage in major surgery." The rules should stress the fact that surgical privileges are not automatic with staff membership, "but require at least minimal qualifications of training and surgery and satisfactory demonstration of individual competency to a designated supervisor or observer during a prescribed probationary period," Dr. Lohr said. The regulations should define how, when and for what length of time the observer will supervise the candidate in his work in order to determine his proficiency, it was added.

Provision for observation during a probationary period, which has been recommended by pertinent councils of the American Medical Association, is "a realistic approach to a difficult problem," the article said. This approach, "recognizes the fact that neither a specialty board certificate nor verbal claims of training and experience are reliable and permanent guarantees that the specialist or the general practitioner applying for appointment is a 'safe' surgeon who will restrict his work in keeping with his limitations, will use good surgical judgment and will be equal to his responsibilities to the patient, his colleagues and the hospital. I am sure that most of us can recall instances where it became necessary to apply restrictions not only to general practitioners but to diplomates of specialty boards as well.

"The plan just described for the improvement of the status of the general practitioner on our hospital staffs will meet his major complaints," Dr. Lohr concluded, "in that it will improve his status in our midst provided, of course, that he is willing to accept the responsibilities and will fulfill the obligations which his demands impose."

Dr. Gilliam to Cancer Institute

WASHINGTON, D.C.—Dr. Alexander G. Gilliam of Petersburg, Va., has been appointed head of the new epidemiology section of the cancer control branch of the National Cancer Institute, it was announced September 15 by Surgeon General Leonard A. Scheele, U.S.P.H.S. As head of the section, Dr. Gilliam will supervise the gathering and classifying of information about cancer: how often it strikes, when, where and, if possible, why.

NEWS...

Patient Turnover More Rapid Than One Year Ago

BURLINGTON, VT.—For the first time since the war, a drop is reported in the daily census of hospitals in New Hampshire and Vermont, the bulletin of the state hospital associations reported last month. At the same time, hospitals point out that in many cases they have as many or more patients than they did a year ago. Turnover is more rapid, however, because the stay of the average patient is shorter than it was a year ago.

A check of a number of hospitals in the two states shows that the "taxed to capacity" condition which has prevailed for many years is giving way to what some officials termed a summer slump of varying degrees, the bulletin reported. Prior to 1942, it is pointed out by hospital superintendents, a decrease in patient census was usual during the summer months. During the war every bed available was in use because of the shortage of physicians. Doctors sought as much as possible to concentrate their patients so it would be easier to take care of them. Now many more doctors are available, and patients are cared for at their homes who during the war would have gone to a hospital.

One hospital reported that during the first seven months of 1948 an average stay for an adult patient was nearly 10 per cent less than in the same period in 1947, a cut from ten days to slightly more than nine days. In the same period, hospitalization of children was reduced from an average of five to four and a half days, the report said.

Interim Meeting of A.M.A. in St. Louis

CHICAGO.—Attention of the medical profession will be focused on procedures and problems of the general practitioner at the second annual interim session of the American Medical Association in St. Louis, November 30 to December 3, according to an announcement from A.M.A. headquarters here.

On the eve of the interim session, Saturday, November 27, the first national medical public relations conference will be held in St. Louis under sponsorship of the A.M.A.

Lecture meetings and a wide variety of clinical conferences on conditions oftenest seen in daily practice will be conducted at the interim session by medical leaders from all sections of the nation.

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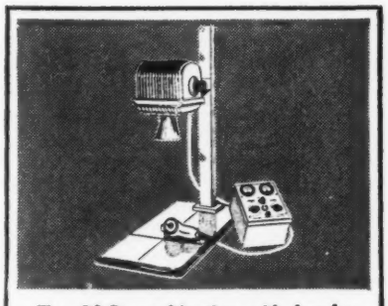

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NEWS...

N.Y. Voluntary Plans Exceed Ewing Goals

NEW YORK.—The voluntary prepayment health service will prove adequate to do the job for which Federal Security Administrator Oscar R. Ewing wants a compulsory insurance system, Dr. Charles Gordon Heyd, president of United Medical Service, declared at a celebration here marking enrollment of the millionth member in the voluntary prepayment medical plan.

Dr. Heyd noted that United Medical Service had achieved its goal of 1,000,000 members "without government coercion."

"New York has never found it necessary to use compulsion to create health conditions that the Federal Security Administrator holds up as the goal for the rest of the United States," Dr. Heyd declared.

"New York State surpasses his figures for general hospital beds per thousand of population and for the number of physicians and dentists per unit of population. In fact, the state of New York far surpasses the requirements quoted in every category listed in the report.

"We have shown that it is possible to give the people of New York State good medical care and free choice of physician through voluntary means," Dr. Heyd concluded.

Auction Benefits Hospital

OAKLAND, CALIF.—For the second consecutive year, the Children's Hospital of the East Bay here will benefit from a special event at San Francisco's grand national livestock exposition when Acacia, a 15-month-old Hereford steer, will be auctioned off to help improve and enlarge the hospital. The auction will be sponsored by the Acacia branch, one of forty branches which enroll 1500 women who act as "godmothers" to the hospital.

Administrator Richard Highsmith admires Acacia II.

NEWS...

Nurses' Association Plans Diamond Jubilee

NEW YORK. — President Truman, former president Herbert Hoover and Senator Arthur H. Vandenberg head a committee of seventy leaders in public life who have joined with the American Nurses' Association in sponsoring the diamond jubilee of nursing, which will be celebrated throughout the country next month, it was announced recently at A.N.A. headquarters.

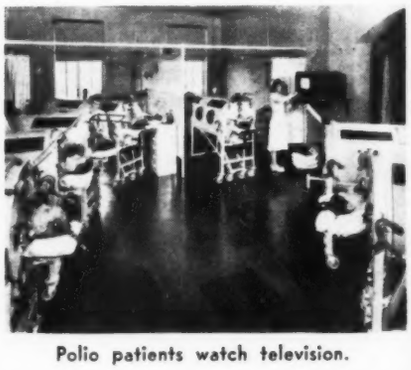
According to Pearl McIver, A.N.A. president, who announced plans for the jubilee, the celebration will be marked by a banquet in New York City November 16. The nursing organization, with a membership of more than 162,000 registered professional nurses, will help "to focus public attention through the jubilee on the extension and improvement of nursing service to all through the improvement of schools of nursing, economic security for nurses, adequate licensure laws and more effective counseling and placement of both prospective students and graduate nurses," Miss McIver said.

"It is hoped that the jubilee will also effectuate the recruitment of the 40,000 additional students for approved schools of nursing desperately needed if professional nursing needs are to be met," Miss McIver added. She said that a coast-to-coast program of activities highlighting the history and progress of nursing to the present day, and paying tribute to the 320,000 registered professional nurses of America, will be initiated during nursing progress week November 14 to 20.

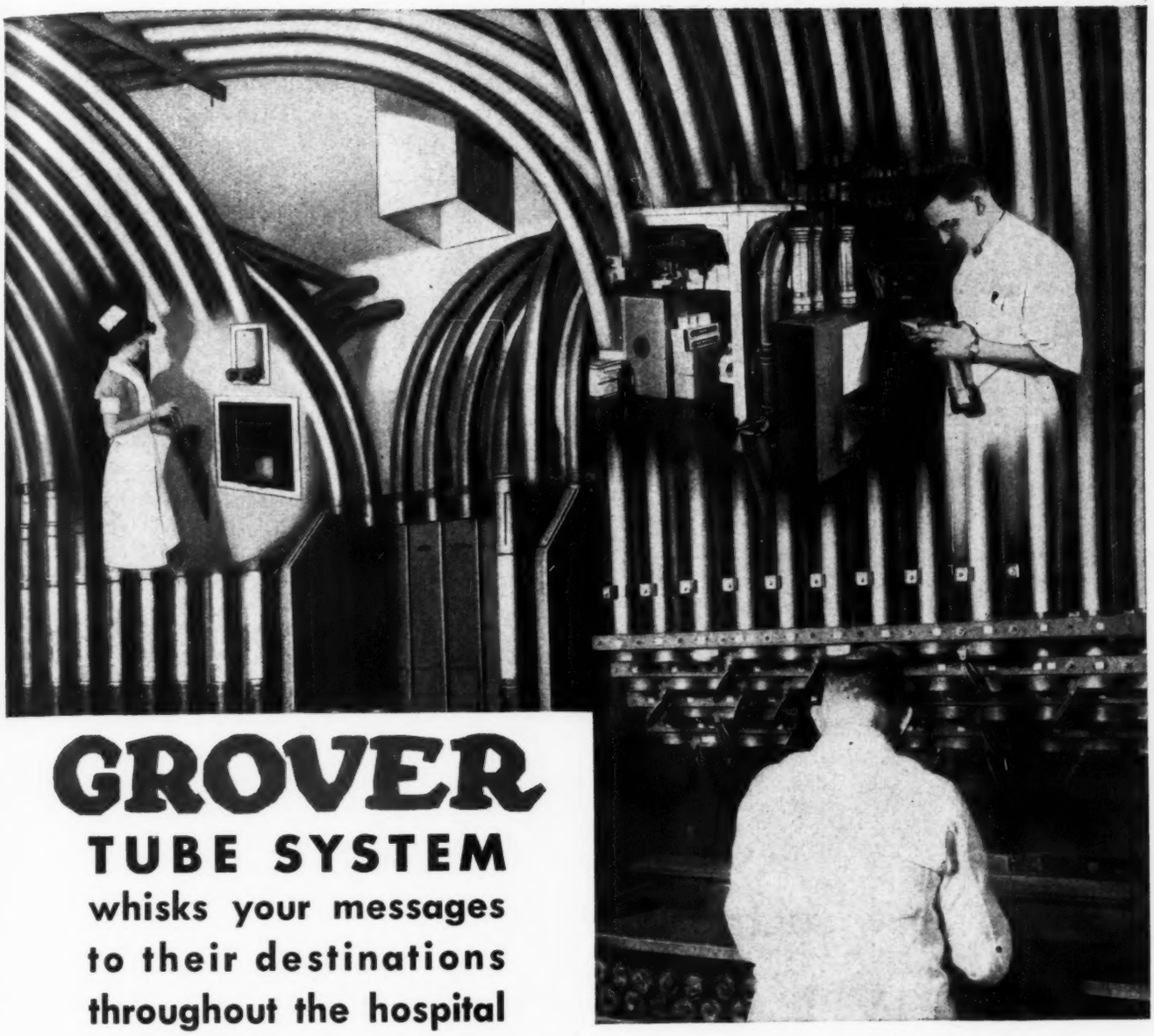
"Ever since modern trained nursing arose in this country seventy-five years ago," Miss McIver said in a statement issued from A.N.A. headquarters, "the profession has moved from height to height, until today the nurse is an indispensable part of American life. Her skill, courage, intelligence, loyalty, tenderness, self-sacrifice and strength of character have served the nation in peace and war. The diamond jubilee will remind us that wherever nature and man assail life, the nurse, eternal aide and colleague of the physician, is there to save it."

Television Set for Polio Ward

BALTIMORE.—A television receiver has been installed in a polioymelitis ward at Children's Hospital here through the interest of the local Rotary Club. The receiver has been so located that a dozen or more youths in iron lungs may view it daily. Staff physicians agreed that much of the victims' tedium would be relieved by daily television entertainment. Special mirrors erected above the patients' heads enable them to view the screen.



Polio patients watch television.



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NEWS...

83 Speakers Will Appear on A.C.S. Clinical Program

CHICAGO.—Information on the program for the 27th annual hospital standardization conference to be held in conjunction with the clinical congress of the American College of Surgeons in Los Angeles, October 18 to 22, indicates that eighty-three speakers from sixteen states, District of Columbia and Canada will appear. Subjects scheduled for discussion by nationally known hospital and medical authorities include developments in medical science affecting hospital administration; hospital facilities and services for members of the medical staff; integration of the general practitioner on hospital staffs; organization of the surgical committee; the point rating system for measuring hospital performance, and hospital and medical public relations.

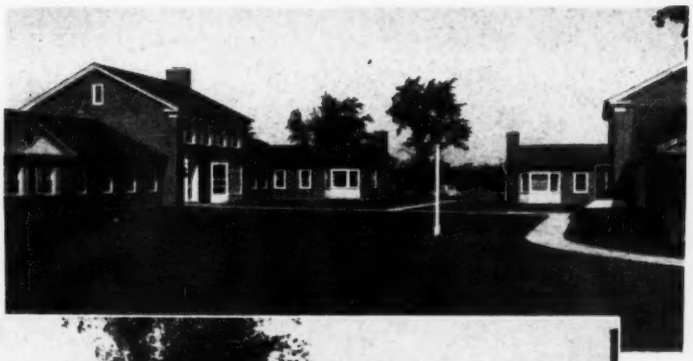
Moderators and discussion chairmen named for the various programs include Dr. Arthur W. Allen of Boston, president of the American College of Surgeons; Dr. Charles B. Puestow of Chicago; Alden B. Mills and Ritz E. Heerman of Los Angeles; George U. Wood and Dr. G. Otis Whitecotton of Oakland, and Dr. Frank R. Bradley of St. Louis.

Radioactive Isotopes Go to 21 Nations

WASHINGTON, D.C. — Twenty-one nations have made arrangements to receive beneficial radioactive isotopes from the uranium chain-reacting pile at the Oak Ridge National Laboratory for medical and biological research, the U.S. Atomic Energy Commission announced September 5.

The twenty-one nations are: Argentina, Australia, Belgium, Canada, Cuba, Denmark, France, Iceland, India, Ireland, Italy, The Netherlands, New Zealand, Norway, Peru, Spain, Sweden, Switzerland, Turkey, Union of South Africa, and the United Kingdom.

During the first year of international distribution, more than 100 research institutions and hospitals in fifteen countries have used or have begun to use the important research tools. Qualified scientists, irrespective of nationality, are permitted to visit laboratories of hospitals, universities and other institutions, both in the United States and abroad, where isotopes are being used in medical and biological research.



Photos, Ward and Mary McMasters, Lake Forest

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NEWS...

New Hampshire May Change Priority Ratings

HANOVER, N.H.—As the result of a new survey of hospital needs in New Hampshire by the advisory council, priority ratings for various areas may be changed, according to Lester K. Billings, assistant director of hospital services. The council is studying needs of small communities and their ability to support enlarged hospitalization facilities, Mr. Billings stated.

Results of the new survey indicate an additional 858 beds are needed to care for patients in New Hampshire. A previous survey report said 446 more beds were required. The council explained that the revision was due to the increase in the state's population and that allocation of federal funds for new hospital construction and improvements has been increased from $342,000 to $367,000 annually on the basis of new studies.

First hospital to benefit from the federal aid program was Mary Hitchcock at Hanover, which has been allocated nearly $300,000 of the first year's funds. Mary Hitchcock plans a new wing for a home for nurses, an education building, and new dining and kitchen facilities, with work scheduled to start next spring.

Five hospitals are now seeking a share of federal funds. These projects are located at Newport, Plymouth, Dover, North Conway, and Conway. Laconia has also indicated it may ask for funds. The advisory council also said health clinics for some small towns will be recommended.

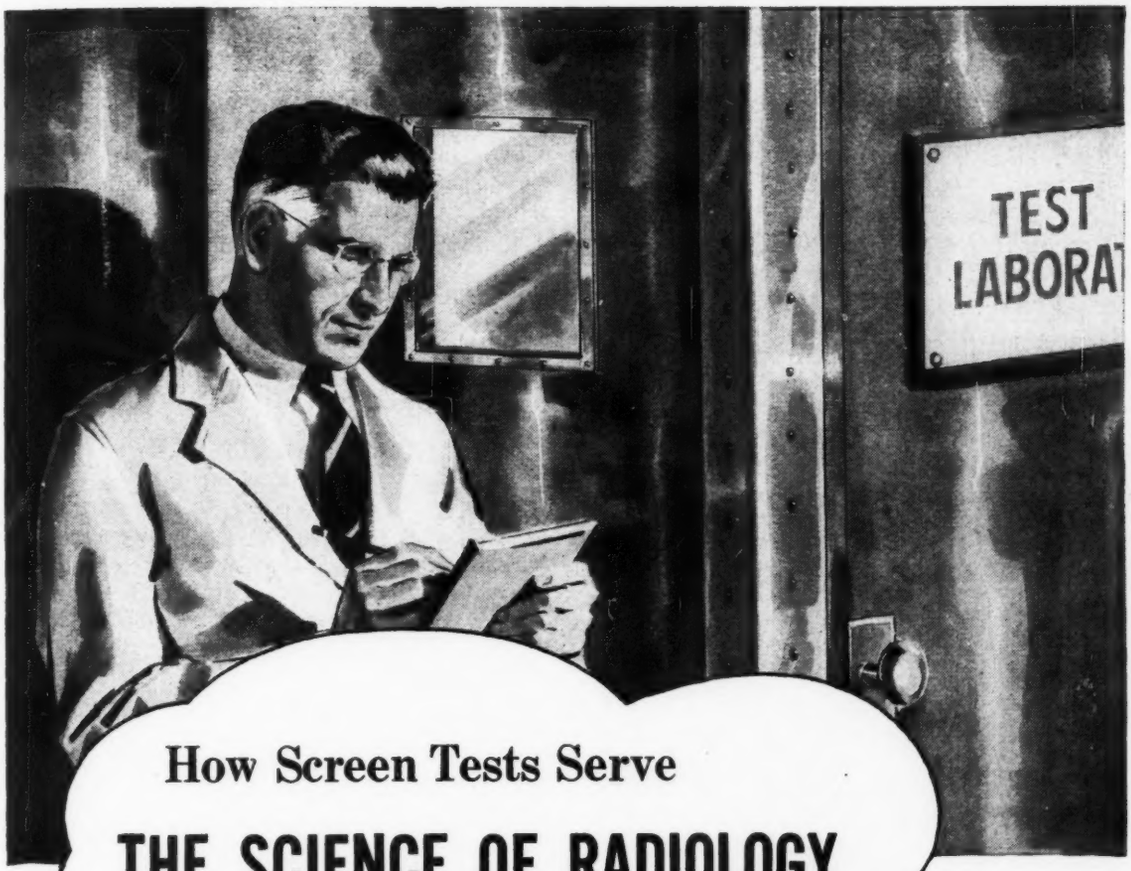
Three Alumni Groups Name Officers

ATLANTIC CITY, N.J.—Irving Gottsegen, assistant director of Montefiore Hospital, New York City, was named first president of the hospital administration alumni of Columbia University during a meeting here in September. Mary Johnson, research associate at the university, was elected secretary of the group. Lawrence J. Bradley, administrator of Genesee Hospital, Rochester, N.Y., was elected president of the University of Chicago alumni group in hospital administration at the annual meeting here in September. Fred Veeder, Barnes Hospital, St. Louis, was named secretary-treasurer of the group.

Northwestern University alumni held their organization meeting at the Hotel Claridge on September 22. Officers named were: president, Jack Hahn, administrator, Memorial Hospital, Fremont, Ohio; vice president, Eva H. Erickson, administrator, Olean General Hospital, Olean, N.Y.; secretary, Bessie Covert, The Modern Hospital Publishing Company, and treasurer, Ray Bolinger, assistant administrator, Robert Packer Hospital, Sayre, Pa.

V.A. Advisory Group Meets

WASHINGTON, D.C.—The advisory committee on medical care to the Veterans Administration met here for a one-day meeting September 13. The group of nineteen members, headed by Dr. Charles Mayo of the Mayo Clinic, holds a conference every six months to discuss problems of medical care pertaining to veterans. The Veterans Administration was represented by Dr. Adrian Freer, acting medical director. Dr. Paul Magnuson, director, was attending international medical conferences in Europe.



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NEWS...

Private Duty Nurse Earns Less Than Stenog

RUTHERFORD, N.J.—The movement to revise nurses' salaries, working hours, sick leaves, and vacations is making progress, according to *Medical Economics,* national business magazine for physicians.

A survey completed and made public last month shows that the average private duty registered nurse is now earning about $38 a week, or less than the average pay of a stenographer.

Radical changes in the structure and economics of nursing—changes that many practitioners feel are long overdue—have been approved by the American Medical Association's house of delegates, *Medical Economics* points out. The American Medical Association committee studying the problem "urges that all nurses be covered by social security and retirement plans," the magazine reports. It urges hospitals to "revise their nurses' salaries, working hours, sick leaves and vacations to bring them more into line with conditions in other professional fields. And since all this will inevitably mean a stiffer bill for the patient, the committee urges that the prepayment principle be applied to all essential nursing services."

"It won't come as cheering news to the American public that it will probably have to buy its way out of the nurse shortage," the magazine concludes, "but that's about the size of it."

Dr. Thomas P. Murdock, Meriden, Conn., is chairman of the American Medical Association's committee. The committee has warned nurses "not to adopt the tactics of organized labor to win improvements."

"Medical men, nurses and other hospital employes have not the right to strike anywhere, any time," the committee stated. "They are dealing with the most priceless possession, life itself."

Indiana University Gets X-Ray Building

BLOOMINGTON, IND.—The award of contracts totaling more than $250,000 and the beginning of construction on an x-ray building at the Indiana University Medical Center in Indianapolis were announced last month by J. A. Franklin, vice president and treasurer of the university.

The new structure will be a one-story addition to the medical center's clinical building and will double the center's x-ray facilities for the diagnosis and treatment of cancer and other diseases.

Funds for the construction recently were allocated by the state budget committee with the approval of Gov. Ralph F. Gates. The Lions' Clubs of Indiana now have in progress a campaign for contributions to provide the most modern x-ray equipment as well as the latest safeguards for the use of radioactive materials, the university stated.

Approximately 5600 square feet of space will be provided by the building for the medical center's x-ray department, which in the last five years has had a 60 per cent increase in the number of examinations and treatments of patients suffering from cancer and other diseases.

The existing overcrowded x-ray department will be augmented by three rooms for diagnostic procedures and five rooms for treatment of patients.

NEWS...

Announces New National Program of Cancer Control

WASHINGTON, D.C.—A new cancer control program calling for a concerted drive by the National Cancer Institute scientists and a group of hospitals and medical schools was announced September 13 by Dr. J. R. Heller, director of the National Cancer Institute of Health, U.S.P.H.S.

Diagnostic tests to detect cancer in its early curable stages will be screened and, when the evidence warrants, will be given a mass tryout through the cooperating hospitals and schools.

The tentative program will include laboratory and clinical investigative studies to be carried out simultaneously in half a dozen cooperating medical schools and hospitals with necessary coordination and direction centering in the National Cancer Institute. Tests that show promise in the laboratories will first be applied to a small number of thoroughly studied cases, and, if justified, to thousands of persons with and without cancer.

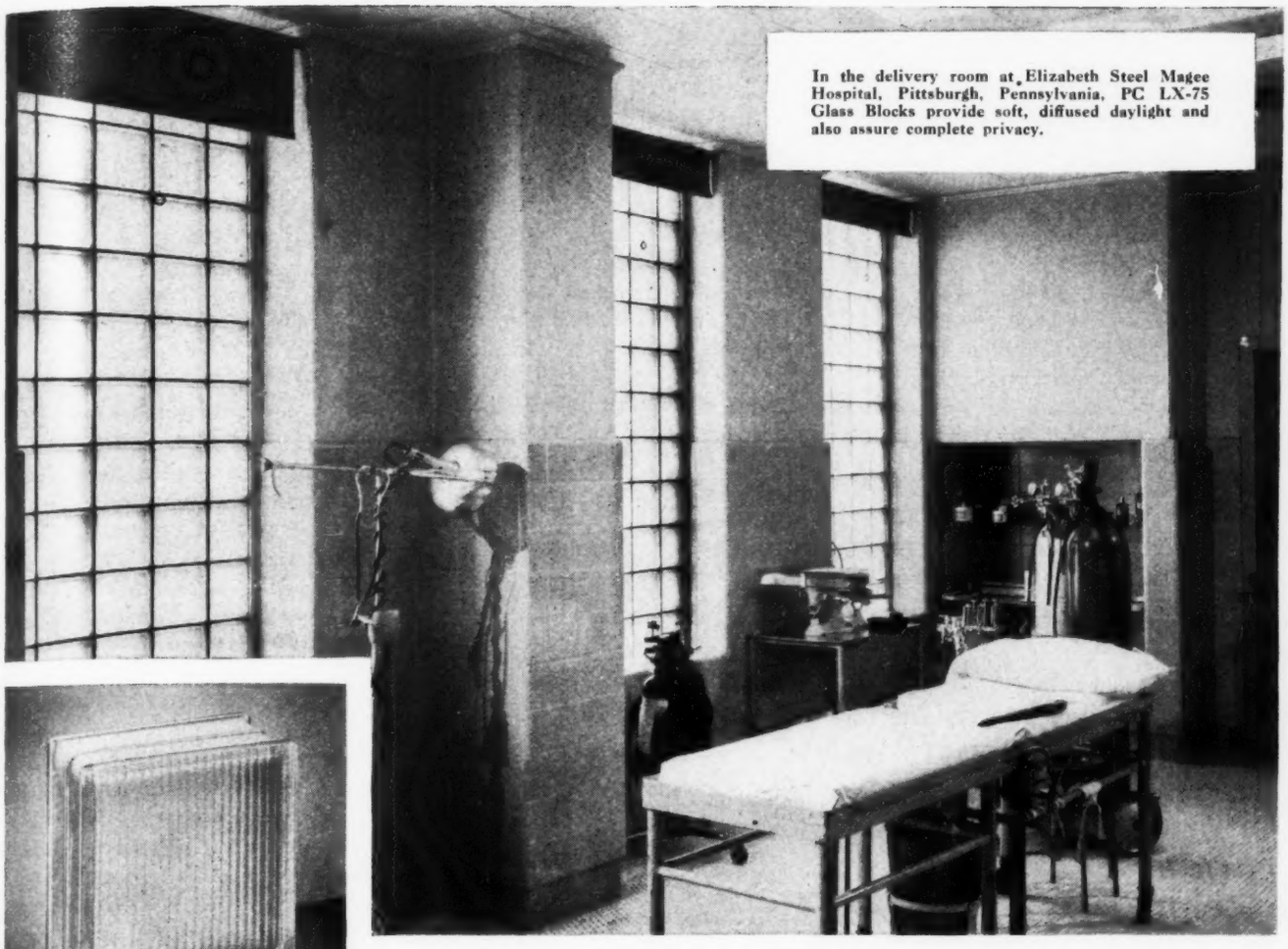
The National Cancer Institute already operates a pilot cancer detection unit, including a cystology laboratory, at the U.S. Public Health Service Center at Hot Springs, Ark.

"One of the most important needs in cancer control is to develop practical, reliable tests that will detect cancer in people apparently free of the disease," Dr. Heller said. "Intensified effort must be aimed at finding the cause and cure of cancer, but at the same time we must try to discover means of early case-finding and diagnosis."

Urges Discontinuance of Small Nursing Schools

NEW YORK.—Small nursing schools with inadequate standards should be discontinued, Dr. Channing Tobias, director of the Phelps-Stokes Foundation, said in an address to the National Association of Colored Graduate Nurses here last month. Dr. Tobias urged that nursing schools' standards be raised. He told association members to renew their efforts to break down discrimination, looking toward the day when Negro nurses will not require their own separate organization.

Approximately 350 members attended the meeting which marked the 40th anniversary of the association.



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NEWS...

Vermont Editor Favors Hospital Cost Study

RUTLAND, VT.—Francis C. Houghton, administrator of Rutland Hospital, has recommended a cost study to determine whether rates should be increased. This suggestion, favored by many other hospital heads in Vermont and New Hampshire, prompted the *Rutland Herald,* in an editorial, to consider the hospital cost problem on a national scale.

"According to Duke University," the editorial said, "this situation has been termed acute, critical and desperate. Almost every item a hospital buys has increased in cost, and living expenses for hospital personnel have gone up as well. The Duke survey shows that in 1940 the cost of giving a single day of care to one patient at a hospital was $5.69. That figure soared to $12.82 by Dec. 31, 1947. Since that time costs have continued to climb.

"There is a slightly brighter side to the picture," the editorial concluded. "Although rates and hospital costs have gone up, it does not cost the patient any more than it did fifteen years ago. Scientific discoveries, such as drugs and x-ray, have enabled the patient to cut his hospital stay nearly one-fourth."

Buck Heads Committee to Direct Affairs of New Hospital Group

TRENTON, N.J.—George H. Buck, superintendent of Mercer Hospital here and past president of the New Jersey Hospital Association, has been named chairman of the joint committee which will direct the affairs of the newly organized Middle Atlantic Hospital Assembly until the first meeting of the assembly in Atlantic City next May, at which time regular officers will be elected. Other officers of the committee are Moir P. Tanner, superintendent of Children's Hospital, Buffalo, N.Y., vice chairman, and John F. Worman, executive secretary of the Pennsylvania Hospital Association, secretary-treasurer.

Other committees at work on planning activities in connection with the assembly are a program committee headed by Mr. Worman; the committee on exhibits, Carl P. Wright of New York, chairman, and the committee on arrangements and attendance, with J. Harold Johnston, New Jersey, as the chairman.

Jewish Hospital Affiliates With Army Medical Corp

BROOKLYN, N.Y.—The Jewish Hospital here has been designated as an affiliated institution with the army medical corps, the War Department has announced. The affiliation is part of the army's nationwide program to activate major hospitals as medical units that could begin immediate operation in the event of military emergency, it was explained. Other hospitals in the New York metropolitan area that have been designated army general hospitals are Queens General, Kings County, Presbyterian and Mount Sinai, hospital officials said.

Under the affiliation agreement, staff members and employes of the hospital have reserve status as medical corps officers and enlisted personnel. Hospitals agree to make available to the War Department adequate space for classrooms and storage of equipment.

NEWS...

Grants for Cancer Control Exceed $1,300,000

WASHINGTON, D.C.—More than $1,300,000 has been laid on the line to finance cancer control and research work, according to word from the National Cancer Institute, September 26. Grants went to hospitals, medical schools, and laboratories throughout the United States, to McGill University in Montreal, Canada, and to the Pasteur Institute in France. The awards were made according to recommendations of the National Advisory Cancer Council and with the approval of Surgeon General Leonard A. Scheele, U.S. Public Health Service.

More than 100 medical and dental schools have qualified for financial aid since the beginning of the program of the Public Health Service less than a year ago. All but twelve recognized medical and dental schools are receiving grants from the National Cancer Institute.

Grants to support forty-six laboratories and clinical research projects in cancer totaled $463,745. In addition, five institutions will receive $447,668 for the construction of facilities for cancer research.

Twelve grants totaling $186,114 were made for special control projects, such as development of laboratory diagnostic tests for cancer, surveys of occupational cancer and training in cytologic test technics. Nine grants amounting to $176,186 were awarded to medical schools to establish or improve cancer teaching courses. Eight dental schools were awarded $37,212.

Battle Creek Community Celebrates 10th Birthday

BATTLE CREEK, MICH.—The Community Hospital here recently made the celebration of the anniversary of its opening the occasion for a comprehensive public relations effort, Vernon T. Root, administrator, reported. Employes who had been with the hospital continuously since its opening were honored at the celebration, and five days' free hospitalization was given to the first baby born on the anniversary date and to its mother, Mr. Root said.

The local newspaper ran a five-column story describing the hospital's operations in detail and outlining its financial problems today, it was reported. Additional features in the newspaper included a picture of the administrator and the five oldest employes, together with a picture of the 10 year old boy who was the first child born in the new hospital.

Heads Hospital Council

INDIANAPOLIS.—Ralph W. Keyes, administrator of Jackson County Schneck Memorial Hospital, has been elected president of the Southeastern Council of Indiana Hospitals, it was announced last month. The council is composed of thirteen hospitals in a seventy-five mile area around Jackson County, it was explained. Council objectives are the exchanging of ideas and pooling of information among small and medium sized hospitals in the area.

Other officers named were: vice president, Helen Boyer of Dunn Memorial Hospital, Bedford; secretary, Fern Hall of Fayette County Memorial Hospital, Connersville.

NEWS . . .

Dr. John B. Youmans Heads Army Hospital

CHICAGO.—A 1000 bed hospital reserve unit, the 427th General Hospital, has been activated by the U.S. Army under the sponsorship of the University of Illinois College of Medicine.

Dr. John B. Youmans, dean of the college of medicine, has been appointed commanding officer. A colonel in the army medical corps reserve, he served as director of the nutrition division, preventive medicine service, Office of the Surgeon General, during World War II.

Commissioned personnel will include fifty-five medical, dental and administrative officers and eighty-three nurses. Monthly training periods have been planned for personnel assigned to the hospital. In the event of mobilization, the hospital would be fully staffed in a minimum of 180 days. Filler personnel would be assigned through selective service or from those who hold reserve appointments.

The 427th is one of two general hospitals sponsored by institutions in the Chicago area that have been activated. The 297th General Hospital has been organized under the sponsorship of Cook County Hospital.

Heart Advisory Council Holds First Session

WASHINGTON, D.C.—The first meeting of the National Advisory Heart Council was held at Bethesda, Md., September 8. Appointment of the twelve members of the council, provided for in the National Heart Act of June 16, had been announced only a short time before.

Members include outstanding national leaders in scientific research, medicine, education and public affairs. The group will serve as the chief consultative body to the Public Health Service in administering the new law.

The council will advise with the National Heart Institute in the development of research programs designed to help in the attack on cardiovascular diseases; review and make recommendations to the surgeon general on applications from institutions or individuals for research and training grants; make a worldwide collection of information on research in heart diseases, and advise on the whole program of the National Heart Institute.

Dr. Cassius J. Van Slyke is the director of the institute.

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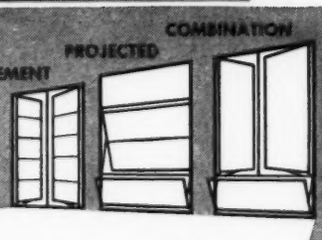

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NEWS...

Cancer Conscious Public Challenges Diagnosticians

CHICAGO.—The public generally is becoming more cancer conscious, according to a study reported in the current issue of *Radiology,* published by the Radiological Society of North America. Drs. Joseph C. Bell and James B. Douglas of Louisville, Ky., state that "for many years physicians have taught that the only hope of control or cure of cancer and allied malignant lesions lay in early diagnosis and adequate treatment.

"This teaching," they add, "is bearing fruit and the public in general is becoming cancer conscious. In the past, many patients having cancer were first seen by a physician from six months to one year from the onset of symptoms. All too often, the lesions were far advanced and the possibility of protracted arrest, or cure, was remote."

The two doctors said in the article that since patients are being seen much earlier in the course of their disease, the difficulties in diagnosis have correspondingly increased. When the disease is in the far advanced stage the diagnosis, of course, is obvious, but when it is in the early stages "the problem of diagnosis is very different and may challenge the ingenuity even of the most highly trained and widely experienced examiner," it is explained.

Pitt's New School to Have $5,000,000 Home

ATLANTIC CITY, N.J.—In an interview following announcement of his appointment as director of the new school of public health at the University of Pittsburgh, Dr. Thomas Parran, formerly surgeon general of the U.S. Public Health Service, told reporters that $5,000,000 of the $13,000,000 Mellon trust gift with which the school was founded will be used to construct a building.

"We have our sights set on admitting the first class in the fall of 1949," Dr. Parran said, "but we may not open until the following year." Recruitment of the best possible faculty is the first job that needs to be done, Dr. Parran explained, and the school will not be opened until the people he wants are on hand.

Plan Public Relations Institute for New Orleans

CHICAGO.—An institute on public relations will be conducted by the American Hospital Association in cooperation with the Louisiana Hospital Association in New Orleans December 6 to 8, it was announced at association headquarters here last month. The purpose of the institute is "to further the development of sound public relations by hospitals and to discuss public relations technics useful in conducting such programs," the announcement said. Hospital public relations directors, administrators, trustees and other interested personnel are eligible to take part, it was explained.

Subjects scheduled for presentation and discussion include public relations problems affecting patients, employes, trustees and staff; hospital auxiliaries; public relations aspects of hospital financing; hospital house organs; press relations, and other technics, the announcement said.

NEWS...

Negro Interns to Work at Gallinger Hospital

WASHINGTON, D.C.—Faculty members and students of Howard University Medical School will serve at Gallinger Hospital, according to an interim agreement reached September 24 by District of Columbia officials and the deans of the medical schools of Georgetown, George Washington and Howard universities.

Howard intern appointments will be made October 15, but the interns will not start serving until July 1. The present complement of thirty-seven had already been appointed before the agreement had been reached.

The dean of Howard University Medical School will nominate up to 25 per cent of the Gallinger Hospital interns. He may also recommend attending physicians and a member of the hospital's executive committee. Georgetown and George Washington will each nominate 25 per cent of the Gallinger intern staff. The District Health Department will name the remaining 25 per cent from medical schools in other communities.

It is planned that as Howard personnel becomes available, Howard's medical school will share all Gallinger posts equally with the other two medical schools.

United Hospital Fund's Goal Is 20% Higher

NEW YORK.—One out of every seven persons in New York City used the city's voluntary hospital facilities in 1947, Henry M. Stevens, chairman of the United Hospital Fund's campaign, said in the opening statement of the 1948 fund raising drive.

"Three out of four of the patients could not afford to be sick," Mr. Stevens said, "but they were sick nevertheless. So the voluntary hospitals cared for three out of four patients at below cost."

The goal for this year's drive is 20 per cent higher than the amount raised a year ago, Mr. Stevens explained, asking that former contributors increase the size of their donations and urging campaign workers to "broaden the base and acquaint many thousands of people who live or earn their living in New York with the essential rôle the voluntary hospitals play in their daily lives."

The goal for the 1948 drive is $2,845,988, Mr. Stevens said.

D.C. Hospitals Get Federal Aid for Construction

WASHINGTON, D.C.—An allocation of federal funds for Children's and Gallinger hospitals was approved by the District Commissioners September 16. The U.S. Public Health Service will give final approval on the allotments. Children's was allotted $589,000; Gallinger, $400,000.

Children's will construct a new main hospital building, its matching funds totaling $1,316,000. This sum represents two years of concentrated fund raising activities on the part of the institution and its supporters.

Gallinger Hospital plans a new pediatrics-crippled children's building and laboratory at an estimated cost of something more than $2,000,000. The new construction will have a three-story wing for pediatrics and a two-story wing for crippled children.

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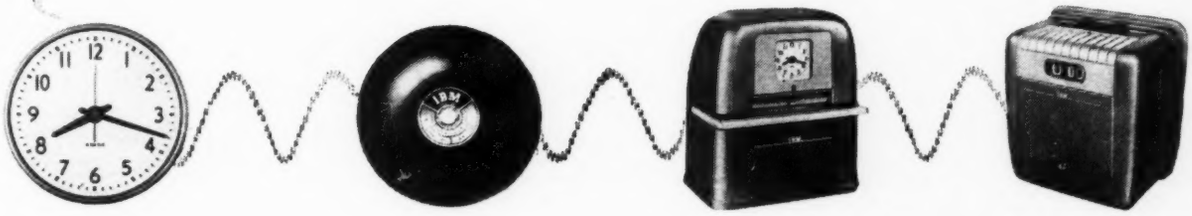

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NEWS...

Trendley Dean Heads Institute of Dental Health

WASHINGTON, D.C.—The National Institute of Dental Health, set up by an act of Congress last June, has been officially established as one of the National Institutes of Health at Bethesda, Md., according to an announcement by Oscar R. Ewing, Federal Security Administrator. Dr. H. Trendley Dean heads the new institute as its director.

The National Institute of Dental Research will conduct a broad attack on dental diseases and related diseases of the mouth. The program, for which Congress has authorized $750,000 yearly, will include research in the institute's own laboratories; financial grants to outside institutions for research and training of professional personnel, and fellowships and traineeships in the institute to promote training and research in dental diseases, their diagnosis, prevention and treatment.

The National Institutes of Health now comprise the National Cancer Institute, the National Heart Institute, the Institute of Experimental Biology and Medicine, and the National Institute of Dental Research.

Hospital Consultants Organize

ATLANTIC CITY, N.J.—An organization of hospital consultants was formed here at the time of the American Hospital Association convention September 20 to 23. The consultants' group will be known as the American Association of Hospital Consultants; twenty-five consultants were named charter members.

Officers elected by the group were: president, Dr. Allan Craig of Neergaard & Craig, New York City; vice president, Dr. Christopher G. Parnall of Ann Arbor, Mich.; secretary-treasurer, Jacque B. Norman, administrator of Greenville General Hospital, Greenville, S.C.

Open Clark Addition

NEENAH, WIS.—A $2,750,000 addition to the Theda Clark Memorial Hospital was opened here last month, Esther C. Klingman, administrator, announced. More than 7000 people visited the hospital on opening day, it was reported. Joseph G. Norby, president of the American Hospital Association, was the principal speaker.

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Administrator
THE LAWRENCE and MEMORIAL ASSOCIATED HOSPITALS

SERVICEABILITY, convenience and economy are but a few of the prime requisites in fulfilling hospital supply needs. When it comes to glassware for bedside serving and for dining-room use, Libbey Heat-Treated Tumblers give you all three!

Establishments—large and small—all over the country—hospitals, restaurants, hotels, clubs, fountains and bars . . . are changing over to Libbey Heat-Treated Tumblers . . . are profiting from four-way savings like these:

1. Reduction in breakage!
2. Less money invested in glassware!
3. Fewer handling hazards!
4. Saving on storage space!

Ask your jobber to show you samples of Libbey Heat-Treated Tumblers o write to us for information.

GUARANTEED
A NEW GLASS IF THE SAFEDGE EVER CHIPS

LIBBEY GLASS

Libbey HEAT-TREATED

Libbey Glass Company, Toledo 1, Ohio

NEWS...

Construction Starts on Delafield Cancer Hospital

NEW YORK.—Mayor William O'Dwyer and Dr. Edward M. Bernecker, hospital commissioner, were the speakers at a ceremony marking commencement of construction of the 300 bed Delafield Cancer Hospital, a $7,000,000 affiliate of the Columbia-Presbyterian Medical Center here.

The hospital will have facilities for deep therapy, radium therapy, chemotherapy, and storage and processing of radioactive isotopes, it was explained, in addition to all usual hospital and medical research facilities. The building was so designed by James Gamble Rogers, architect, that additional stories may be added to accommodate 250 more beds.

At the cornerstone ceremony, Dr. Bernecker said that the mayor and other city officials were doing everything possible to expedite completion of the Delafield Hospital and the Ewing Memorial Hospital now under construction at Memorial Hospital for cancer and allied diseases. "Cancer today stands next to heart disease as the greatest human killer," Dr. Bernecker declared. "The Delafield and Ewing hospitals are the answer of the city administration to the challenge of this dread killer."

Forms Advisory Group to Children's Bureau

WASHINGTON, D.C.—A forty-member group of producers and consumers of health services for mothers and children has been established as an advisory committee to the Children's Bureau, according to an announcement September 19.

This new committee is the first in the child health field, with representation both of professional and of nonprofessional groups, to be given the broad mandate of advising the Children's Bureau on matters of public policy affecting the promotion of better health for mothers and children.

Members include: officially designated representatives of medical, hospital, nursing, dental, medical social work, physical therapy, and dietetic associations; representatives of voluntary health agencies; leaders in labor, farm, women's and veterans' groups; specialists from graduate schools in medicine and allied sciences, and other distinguished citizens.

Conference to Explore Gastric Cancer Research

WASHINGTON, D.C.—The National Advisory Cancer Council in session for two days at Bethesda, Md., has called a national conference of medical scientists to consider what can be done to reduce the number of deaths from gastric cancer. The meeting will take place in San Francisco December 13 and 14. The scientists will assay research progress and explore research leads to methods of early diagnosis.

The Public Health Service has for a number of years conducted a program of grants-in-aid specifically planned to develop the research field of gastric cancer. Research at present under way covers: attempts to show the relationship between cancer and diet; the possible influence of hormones on gastric cancer; the part, if any, that pernicious anemia and ulcers play, and the part, if any, of heredity. Some twenty-three grants totaling $261,424 are being devoted to these projects.

NEWS...

Federal Aid Granted for Psychiatric Training

WASHINGTON, D.C.—To foster training of medical students in the mental aspects of disease, federal grants for undergraduate courses are now being offered to medical schools by the U.S. Public Health Service, according to an announcement September 10.

Formerly such grants were utilized primarily for graduate training in psychiatry. Applications must be made to the Mental Hygiene Division, U.S.P.H.S., by October 15. Grants will cover a three-year period, beginning July 1, 1949, and will be paid in annual installments.

At present, funds are limited and some selection of schools will be necessary. Eventually, however, it is hoped that grants can be made to all schools desiring such assistance. Selection of schools will be based on recommendations made by the National Advisory Mental Health Council to the surgeon general. Amounts to be allocated to each school will also be based on council recommendations.

It will not be possible for a while to make large grants to any single school. The maximum for the first three-year period will probably not exceed $37,500.

Medical Education Only for the Wealthy?

NEW YORK.—Increased public support of medical education is necessary to keep the profession democratic, Dean Currier McEwen of New York University College of Medicine stated at the opening of the 109th college year last month.

Medicine may become exclusively the profession of the well-to-do unless added public support helps to defray part of rising tuition costs, Dean McEwen said.

Average tuition fee for the nation's medical colleges this year is $513, according to American Medical Association statistics. This represents only 25 per cent of the operating cost of the medical school, Dean McEwen reported. The rest must be made up from endowments, gifts, university funds, and tax sources, it was explained.

Quarantine Rules Eased Between U.S. and Canal Zone

WASHINGTON, D.C.—Public health quarantine regulations of the Canal Zone and the United States have been coordinated to facilitate maritime and air commerce, according to an announcement by the Secretary of the Army and the Federal Security Administrator.

Since September 1 ships and aircraft receiving complete public health quarantine clearance at a port in one of these areas are not required to undergo quarantine inspection on arrival at the other area, unless stops are made at a foreign country en route.

Quarantine inspections are made primarily to prevent transportation of the internationally designated "quarantinable diseases." These are cholera, plague, typhus, smallpox and yellow fever.

Launch Joint Campaign

GREEN BAY, WIS.—St. Mary's and St. Vincent's hospitals here have announced that they will launch a campaign for $1,000,000 to provide needed additional facilities.

Now . . . Raglan Sleeves

and French Double Seams!

in a new Surgeons' Operating Gown made of Rhoads' famous

"DREADNAUGHT"

Here's a surgeons' operating gown that for the first time combines the *extra* comfort and freedom of movement of a raglan cut sleeve, with the *extra* durability of French double seams!

Laboratory tests *prove* that these flat double seams *will not tear out.* That's because they are so very much stronger than the fabric itself. The cheaper single seam stitching is only ⅔ as strong as the fabric and therefore frequently breaks before the gown wears out.

This extra seam strength and the superior wearing qualities of famous "Dreadnaught" (the fabric that is 51% stronger than Jean Twill in the weaker direction) mean greatly increased wear and washability. The savings in repair and replacement they will bring you make the new Double Seam Raglan Surgeons' Gowns the most economical you can buy. *Made in our own factory and sold direct.*

Additional Features

- Extra overlap at back closing to insure absolute sterility.
- With or without stockinette cuffs.
- Strong reinforced belt.
- Generous cut throughout.
- Medium and large sizes.

Prices: $37 per doz.; $35.75 per doz. for 12 doz.; $34.75 per doz. for 24 doz.; $32.95 per doz. for 48 doz. *Samples on request.*

IMMEDIATE DELIVERY

or any delivery up to November 30 with prices guaranteed. If you'd rather phone your order, don't hesitate to reverse the charges. The number is WAlnut 2-8922.

RHOADS & COMPANY

FIFTY-SEVEN YEARS OF DEPENDABLE SERVICE TO HOSPITALS *Philadelphia*

NEWS...

Lectures on Emotional Problems of Patients

CLEVELAND.—Hospital patients are usually emotionally upset and need as much sympathy and understanding as conditions will permit, Dr. Alfred K. Bochner of Western University said in a lecture for professional nurses at the university here early this month. Dr. Bochner is presenting a series of lectures to nurses on the emotional aspects of common problems in behavior under the sponsorship of the Frances Payne Bolton School of Nursing.

The art of listening to patients depends on the nurse's understanding of her own as well as the patient's emotions, Dr. Bochner believes. The nurse or doctor who fails to listen sympathetically to the emotionally upset patient is likely to aggravate emotional distress in the patient, he said.

"Nurses should condition personal attitudes to the needs of individual patients. The nurse who is hasty or over cheerful with a sensitive and depressed patient creates an emotional problem for him," Dr. Bochner pointed out. The lectures are made possible through a W. K. Kellogg Foundation grant.

County Campaign Oversubscribed

BEDFORD, PA.—The people of Bedford County have contributed $625,000 toward the cost of a new voluntary hospital to be constructed here under Public Law 725, Paul I. Detwiler, president of the hospital building fund campaign, reported last month. The amount raised was more than the minimum objective sought, Mr. Detwiler said, and ultimately may exceed $700,000. The campaign was characterized by Mr. Detwiler as "the most notable money raising campaign in Bedford County's history."

75 Per Cent Enrollment

PROVIDENCE, R.I.—Approximately 75 per cent of the eligible population of Rhode Island is now enrolled in the Blue Cross plan, Stanley H. Saunders, executive director of Hospital Service Corporation of Rhode Island, announced recently. Total enrollment in the plan was 544,244 on October 1, Mr. Saunders said. This number represents 74.96 per cent of the eligible population, he added. Mr. Saunders reported that the recent direct enrollment campaign resulted in about 15,000 new members.

"The Flowers were like a visitor from home!"

Flowers by Wire really bring lively cheer...
like a visitor from home. The flowers tell patients,
"We're thinking of you...get well soon".

Minimum handling necessary by hospitals

It's standard practice by almost all F.T.D. florists to deliver flowers already placed in containers with chemically treated water adequate for their life. No vase preparation. No water changing. They can be taken direct to the patient's room.

FLORISTS' TELEGRAPH DELIVERY ASSOCIATION
149 Michigan Avenue, Detroit 26, Michigan

For the second year, F. T. D. members are cooperating in the Student Nurse Recruiting Program

NEWS...

Hospital Train Sits on Convention Hall Siding

ATLANTIC CITY, N.J.—A.H.A. convention delegates took time out of a crowded week to file through a hospital train which the army sent as an educational exhibit. One reporter described it as follows:

If the flatware is marked "USAMD," you may be dining on a hospital train. In that case the meals are prepared on a coal range and served in divided metal trays with disposable linings. If a kitchen car isn't attached to the train, you can still eat for each ward car has a kitchenette, along with showers and toilets, sleeping quarters for the nurse, a baggage compartment, and an operating room.

A hospital train is exactly as you had imagined a hospital train only it fits tighter. Nothing can be added; nothing seems to be left out.

Once a person gets in a hospital train —as thousands did in the two-car train at the Atlantic City convention—and becomes adjusted to the complete compactness of it all, he begins to wonder why the designers didn't put something in this free space or that.

It takes a moment to realize that the unoccupied areas consist entirely of air and aisle. The patients and staff have to breathe, even though under emergency conditions the staff may have little time to, and in those aisles doctors, nurses attendants, cooks and ambulatory patients do their trafficking back and forth, also up and down, the wards being three beds high. Indeed, in one central sector, the aisle becomes the surgical theater, a reinforced litter serving as operating table.

Nests, tiers, convertibles—a hospital car has them all, and in addition an ash tray above every bed. The one item that may have been overlooked is elbow room, and there is considerable impropriety in elbows anyway.

Hospital administrators who toured that train went home a little wiser about space utilization, a little less bitter about cramped quarters, and a little more determined to duplicate army neatness and precision.

Federal Funds for Texas Cancer Hospital

HOUSTON, TEX.—A $500,000 allocation of federal funds may mean the beginning of construction early next year of the University of Texas M.D. Anderson Hospital for Cancer Research, Dr. R. Lee Clark Jr., director of the hospital, reported last month. Approximately $3,000,000 is available to supplement the $500,000 grant that was authorized by the state board of health under the federal Hospital Survey and Construction Act, Dr. Clark said.

The grant of $500,000 is for 1948-49, and University of Texas authorities have urged that a similar grant be made each year for the next two years to assist development of the cancer hospital, which now occupies temporary buildings.

The new hospital will be constructed within the Texas Medical Center. Together with the dental school, a school of public health and a postgraduate medical school, it will comprise the University of Texas units within the medical center.

Construction may begin early next year on the dental school building, as well as the hospital, it was added.

Rh tests in 2 minutes or less!

Human blood grouping serums from American—fast, potent, stable, accurate—are saving time for hospital staffs from coast to coast. First to offer nationwide distribution of human Anti-Rh_o and Anti-Rh_o' serums, American now has added hard-to-get Anti-Rh″ and Anti-Hr′ to its line. All are prepared in strict accordance with N.I.H. specifications. All but Anti-Rh″ (a test tube serum) utilize the quick and simple slide technique, with cell action clearly visible to the naked eye in seconds.

Introduced by American Hospital Supply Corporation, this line of human blood grouping serums is further evidence of American's leadership in discovering and procuring . . . conceiving and developing . . . the better products, better equipment, that make our hospitals finest in the world.

Let the American man help you plan your hospital's future. It pays.

PLAN WITH AMERICAN . . . the first name in hospital supplies

American Hospital Supply Corporation

GENERAL OFFICES . . . EVANSTON, ILLINOIS

ABOUT PEOPLE

(*Continued From Page 90.*)

of Chicago for two years and assistant director of nurses at the Illinois Training School for Nurses for five years. Miss Newman is a graduate of the Philadelphia General Hospital School of Nursing and has a master's degree from Teachers College, Columbia University.

Margaret Margrave, personnel director of Wesley Memorial Hospital, Chicago, since 1946, has resigned to accept an assignment in the National Blood Program. Miss Margrave will serve in an administrative capacity with the American Red Cross, headquartering in Alexandria, Va.

Neola Northam has joined the staff of the Children's Memorial Hospital, Chicago, as director of public relations. Miss Northam was club editor and society reporter for the *Chicago Sun* from 1941 until January 1948.

Dr. Jacque E. Miller has assumed his duties as director of the radiology department at St. John's Riverside Hospital, Yonkers, N.Y. He succeeds **Dr. Romeo Roberto,** who resigned so that he might devote more time to private practice. Dr. Miller was associated with New York Hospital as associate radiologist and instructor of radiology in Cornell Medical Center.

Mona Jackson, formerly superintendent of nurses at Iowa Methodist Hospital, Des Moines, is the new director of the school of nursing and of nursing service at Grant Hospital, Chicago.

A. Elizabeth Gallaway became director of nursing and nursing education at Augustana Hospital, Chicago, on September 1. She was formerly director of nursing at Bethesda Hospital, Zanesville, Ohio.

Miscellaneous

Dr. Thomas Parran

Dr. Thomas Parran, who retired last April after twelve years as surgeon general of U.S. Public Health Service, has accepted an appointment as director of a new graduate school of public health to be built at the University of Pittsburgh Medical Center, it was announced last month. Establishment of the school was made possible by a $13,600,000 grant from the A. W. Mellon Educational and Charitable Trust. Plans include construction of a new psychiatric hospital at the medical center site, Dr. Parran said at a press conference.

Louis S. Reed is now chief, office of special services, Division of Hospital Facilities, U.S. Public Health Service. The special services provide program analysis and statistics on the hospital construction program.

Dr. Robert J. Anderson took over as medical director and chief of the Tuberculosis Control Division of the U.S. Public Health Service in Washington, D.C., September 1. He succeeded **Dr. Francis J. Weber,** who resigned to do postgraduate work at Johns Hopkins University. Dr. Anderson is a graduate of the University of Minnesota School of Medicine and holds the degree of master of science in public health from Columbia University.

Mrs. Gladys R. Jacoby Wilson, for the last fourteen years supervisor of the nursing bureau of the New Haven Health Department, has been appointed North Atlantic area supervisor of centers nurses in the National Blood Program.

NEWS...

Ruth B. Freeman, administrator of American National Red Cross Nursing Services, has been lent for three months to the National Security Resources Board to serve as chief of the nursing section of its medical services division. Her function with the planning board will concern consideration of national nursing resources with a view toward solving the problem of maintaining a full complement of nurses to balance both civilian and military needs.

Anna K. Magnussen has been appointed national deputy administrator of nursing services, American Red Cross. Miss Magnussen has been national director of disaster nursing and nurse enrollment since early in 1947.

Fred T. Foard has been appointed director of health of the Bureau of Indian Affairs, Surgeon General Scheele of the U.S. Public Health Service announced September 7.

Dr. Foard, a graduate of the University of Maryland Medical School, was director of District No. 6 of the Public Health Service in Puerto Rico and the Virgin Islands prior to his recent appointment.

Muriel Crothers Henry has been appointed to handle public relations for the Committee on Careers in Nursing, sponsored by the six national nursing organizations. Mrs. Henry, recently director of public relations for Chicago Travelers Aid Society, obtained a B.A. in journalism at the University of Washington and has done additional work at New York University and the University of Chicago.

Marguerite M. Ducker, director of research for the program in hospital administration at Northwestern University, has been appointed assistant director of the program and is responsible for arranging the curriculum.

Deaths

Will C. Braun, business and circulation manager of the American Medical Association for fifty-four years, died September 12 in Chicago. He was 80 years old.

William E. Haugaard, 59, formerly state architect for New York, died last month. Mr. Haugaard served as state architect from 1928 until 1944 when he returned to private practice in New York City. Among the hospitals he designed were the Pilgrim State Hospital at Brentwood, L.I., said to be the world's largest mental hospital, and the Halloran General Hospital on Staten Island, which became a great army medical center during the war.

Col. Julia C. Stimson, first woman major in the Army Nurse Corps and recipient of the Distinguished Service Medal for her overseas activities in World War I, died September 30 following surgery. Miss Stimson, who became colonel after her retirement, was president of the American Nurses' Association from 1938 to 1944.

M. Adelaide Nutting, 90, first nurse to receive a professorship in any university, and author with Lavinia L. Dock of the two volume "History of Nursing," died October 4 after a long illness. Miss Nutting was for many years director of the department of institutional administration and of the division of nursing education at Teachers College, Columbia University. At that school is housed the Adelaide Nutting Historical Nursing Collection, containing an extensive Nightingale library and other Nightingaliana.

Georgetown U. Hospital Opens Cancer Clinic

WASHINGTON, D.C.—The new cancer detection clinic which opened at Georgetown University Hospital September 7 was booked even before its opening date through October, according to Sister Mary Antonella, the hospital's administrator.

The clinic's examinations are complete in that they include a thorough physical check, laboratory and x-ray tests and any other tests that may be indicated. "Donations" of $15, which cover only a partial cost of the examinations, are charged.

Dr. John C. Sullivan has been made head of the new clinic set up in accordance with the Cancer Control Committee of the District Medical Society. The clinic is partially supported by grants from the American Cancer Society.

An increase from $10 to $15 in fees from persons examined in cancer detection clinics here has just been announced by the District-Medical Society's Cancer Control Committee.

What's New FOR HOSPITALS

OCTOBER 1948 Edited by BESSIE COVERT

For further information on new products see coupon on page 280

Film Reader-Desk

Reference to micro-records can be facilitated through the use of the new Film-a-record Reader-Desk. The unit permits fast service and the manufacturer reports testing an inexperienced operator who could load the reader and locate any image on a 100 foot roll of indexed film in less than 60 seconds without leaving her chair.

Film can be moved through the Reader-Desk in either direction as fast as 150 feet per minute and brought to a full stop instantly by turning a single control knob, thus leaving one hand free for transcriptions. Loading, focusing and image positioning are all accomplished in a recess located at the base of the screen. A 14 by 14 inch screen enlarges documents to original size or larger and the scientific tilt and specially coated screen reduce eye strain. All parts can be easily reached for cleaning, inspection or servicing and the unit is 36 by 27 inches. **Remington Rand Inc., Photo Records Div., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 168)**

Visiband Dressing

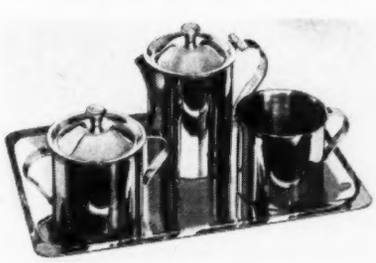
Visiband is a transparent, non-adhering dressing for burns, abrasions or any surface wound. This improved, new type dressing consists of a perforated strip of transparent dressing material on which any desired ointment or medication is applied. This is placed over the injured area, covered by an unperforated piece of the transparent material and any type bandage is used to hold it in place.

The wound can be inspected without removal of the Visiband since it is transparent but when it is necessary to remove the entire dressing it can be done without discomfort to the patient since it is non-adherent. Visiband is sterilized, economical, easy to apply and is designed to prolong the effective period of medication. Each Visiband is in a sterilized, individually sealed envelope. **The Quicap Company, Inc., Dept. MH, 233 Broadway, New York 7. (Key No. 169)**

Bobtail Fountain

The Bobtail Fountain is a new 6 foot 6 inch addition to the Liquid Carbonic line which incorporates 3 basin sinks 10 by 14 by 12 inches with 2 combination swing faucets. It is available in either single or double station with provision for the addition of a third draft arm. Hospitals installing lunch rooms, drug stores or gift shops with soda fountain facilities might find this small unit suitable to their requirements. It is available in self-contained or remote models. **The Liquid Carbonic Corp., Dept. MH, 3100 S. Kedzie, Chicago 23. (Key No. 170)**

Stainless Steel Tea Set



Vollrath has developed a stainless steel tea set with attractive, modern lines which should be especially useful for hospital food service since it makes up an attractive tray and at the same time is easy to keep clean and bright. Consisting of a 10 ounce teapot with hinged cover and cool handle, covered sugar bowl, 7½ ounce creamer and rectangular tray without sharp corners or crevices, the service is durable, easy-to-clean and inviting in appearance. **The Vollrath Co., Dept. MH, Sheboygan, Wis. (Key No. 171)**

Centralinear Vertical Control

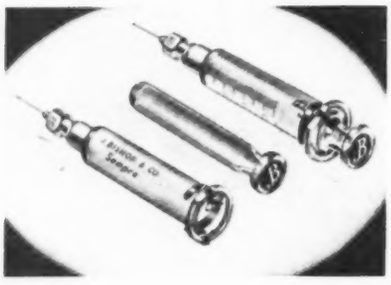
The new "Pushbutton" type Centralinear vertical control is a streamlined unit perfected for 200 ma x-ray equipment. The Milliamperage Selector, which reduces the number of movements required to make a radiographic exposure by 50 per cent, is the outstanding feature of the control. The unit is also highly versatile, adapted to radiography, fluoroscopy, superficial therapy, spot-film radiography and photo-roentgenography.

The Milliamperage Selector button is used to select the proper tube, select the desired focal spot, set the ma value, choose the milliameter scale and connect the timer, thus relieving the technician of these separate operations. The interior mechanism of the control is readily accessible through a front-opening panel, thus making it possible to service the unit without loss of time. Glare and shadow on the dials are reduced by backlighting. **General Electric X-Ray Corp., Dept. MH, 4855 W. McGeoch Ave., Milwaukee 14, Wis. (Key 172)**

Nylon Hand Brush

An all nylon surgical hand brush has been developed which is designed to withstand the temperatures and moisture of steam autoclaving for any reasonable time and to be virtually unbreakable. It is attractive and modern in design and is made with Du Pont nylon bristles anchored in a sterilizable Du Pont nylon plastic back. **Anchor Brush Co., Dept. MH, Aurora, Ill. (Key No. 173)**

Sempra Syringe



The new Sempra Syringe has interchangeable barrel and plunger, thus no identifying marks are needed and there is no time lost in searching for matching parts. The metal tip is permanently attached by a method which does not weaken the barrel-tip, thus reducing the tendency toward breakage. The new type permanent markings are accurate, easy to read and cannot wear off or dim through usage. Use of the new syringe should permit savings in time and money. **J. Bishop & Co. Platinum Works, Dept. MH, Malvern, Pa. (Key No. 174)**

Dishwashing Machines

The new 0-AWR and 1-AWR Champion dishwashing machines are single tank, hand feed machines equipped with an automatic timing device which guarantees a definite predetermined wash and rinse cycle. The timing cycle is set on the machine for the user's requirements so that when the machine is loaded and the starter button pushed, the required washing and rinsing time must elapse before the machine automatically stops.

Each machine has a capacity of approximately 1000 dishes per hour, is constructed of galvanized iron and stainless steel, has all parts easily accessible for cleaning and is constructed for long, efficient service. **Champion Dish Washing Machine Co., Dept. MH, Erie, Pa. (Key No. 175)**

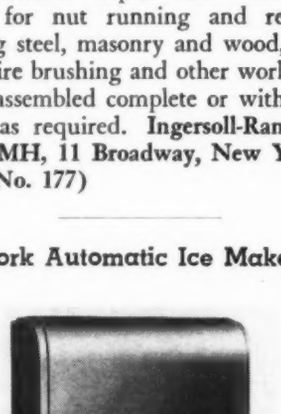
Oxygen Administering Apparatus

The new Heidbrink Model 13 Oropharyngeal Catheter Oxygen-Administering Apparatus features an optimum degree of humidity obtained through the use of a principle of atomization. The unit is low in initial cost and economical in the use of oxygen. The control mechanism consists of a two-stage adjustable pressure-reducing regulator with a gauge to register cylinder pressure and a Bourdon-type flowmeter. Gas flows at any desired rate into the humidifying jar before being delivered to the patient through a nasal catheter. The complete unit may be mounted on the oxygen cylinder and is also available for mounting on the manifold of a central oxygen-piping system. **Ohio Chemical & Mfg. Co., Dept. MH, 1400 E. Washington St., Madison 10, Wis. (Key No. 176)**

Tool Kit

A compact, portable tool kit has been designed to save time in maintenance jobs while providing the needed tools. A feature of the kit is the new Ingersoll-Rand electric impact tool with accessories for nut running and removal, drilling steel, masonry and wood, reaming, wire brushing and other work. The kit is assembled complete or with accessories as required. **Ingersoll-Rand Co., Dept. MH, 11 Broadway, New York 4. (Key No. 177)**

York Automatic Ice Maker



The York Model 450 Automatic Ice Maker not only produces ice cubes automatically with a capacity up to 450 pounds, or approximately 8000 cubes of ice, per day, but the ice cubes are made with a hole in the center of each, thus preventing "sweating" or freezing together during storage.

The unit is equipped with a standard bin for storage of the ice cubes and is so designed that the front panel and top are easily removable for access to all working parts. The unit is well insulated to reduce noise to the minimum and to prevent the forming of moisture on the outside. It has an attractive exterior design of bonderized steel finished in glossy neutral gray and trimmed with stainless steel.

Operation of the unit is entirely automatic, it being necessary only to turn the on or off switch. The storage bin has two sliding stainless steel doors for access to the ice cubes and holds approximately 4000 cubes at a filling. The bin fills automatically during a demand period. **York Corporation, Dept. MH, York, Pa. (Key No. 178)**

Advanced Design Metal Desks

The new "Mode-Maker" metal desks have been designed for executive and other office use. There are no sharp corners or projections of any kind on the exterior of the desk which is the standard GF gray gloss finish. The line is extremely flexible, comprising 35 different models, including sizes and types to fit any office requirements.

The heavy reenforced steel top is covered with velvoleum and a double anodized aluminum binding and a hard composition edging protect the top. The pedestals are complete units with all edges rounded. Space is provided for electrical equipment and interchangeable drawers permit arrangement to meet differing requirements.

Anodized aluminum legs are available in two heights for desks either 29 or 30½ inches high and may be quickly changed. The design of the pedestal and leg eliminates interference with the user's feet and facilitates the cleaning of floors. **The General Fireproofing Co., Dept. MH, 1404 Terminal Tower, Cleveland 13, Ohio. (Key No. 179)**

Underwood Duplex Carbon and Fabric Ribbon Machine

The new Underwood Typewriter equipped with Duplex Carbon and Fabric Ribbon feature permits its use for high quality lithographic reproductions of typewritten material, either by photo offset or by direct offset processes. The fabric ribbon feature permits use of the machine as a general purpose typewriter. It is available in the same variety of carriage widths and type styles as standard Underwood typewriters and has all of the desirable Underwood qualities.

The carbon paper feed mechanism, designed for 400 foot ribbon reels, feeds only when operating the type bar keys and a special mechanism equalizes stress

on the ribbon and eliminates breakage. **Underwood Corporation, Dept. MH, 1 Park Ave., New York 16. (Key No. 180)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 280

Film-Developing Camera

A camera was recently announced which completely develops moving photographic paper or film four seconds after exposure is made. The camera was developed for the electrocardiograph to provide immediate viewing of the record of heart action to assist in detection and diagnosis. The same process has been used with x-ray film and can be applied to the entire field of photography.

The entire process, including developing, fixing, washing and drying, takes place within the camera so that with the electrocardiograph, the continuous photographic record of the heart action rolls from the camera as the cardiogram is being made, thus permitting immediate reading as the examination progresses. The camera can also be used for immediate development of x-ray film during emergency operations. **Beck-Lee Corp., Dept. MH, 630 W. Jackson Blvd., Chicago 6. (Key No. 181)**

Econotherm Steam Generator

The new Dutton Series 40 Econotherm Steam Generator is designed to save considerable space in the installation of package type steam generators. It has many other advantages and improvements including the introduction of preheated secondary air direct to the combustion chamber, eliminating unnecessary resistance; elimination of unnecessary draft which reduces fan speed and results in quieter, smoother operation; boiler feed pump and condensate return system in a separate unit thus giving greater flexibility of boiler room arrangement, and every advantage in safety, economy, combustion efficiency and automatic control. **C. H. Dutton Co., Dept. MH, Kalamazoo, Mich. (Key No. 182)**

Royal Portable Typewriter

The new Royal portable typewriter has been designed by Henry Dreyfuss, industrial designer, with great functional beauty and eye-appealing proportion of height to width to depth. Finished in two-tone gray and black, the machine has finger form keys constructed scientifically to follow finger contours and to give greater finger clearance.

Other features of the new machine include the new Speed Spacer which is built into the frame to speed spacing action and provide broader striking surface; the new Rapid Ribbon Changer to simplify ribbon changing; the larger and more-accessible Line Finder; newly designed Line Space Selector, and several other new mechanical improvements in addition to the standard Royal features. **Royal Typewriter Co., Inc., Dept. MH, 2 Park Ave., New York 16. (Key No. 183)**

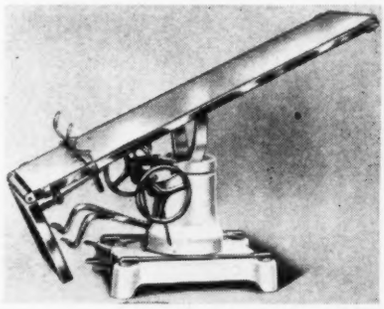
Wappler Diathermy Unit

The Wappler Model VC-4000 Diathermy Unit is designed to provide effective, dependable deep-heat therapy.

It has great flexibility of treatment application since it can be used with concave inductor, inductance cable, circular condenser pads as well as for surgical procedures. It is simple in operation with conveniently located power outlets and any of the treatment accessories can be quickly connected or removed. The applicator pads are readily adjusted to body contours without the use of tapes or straps and the inductance cable can be easily placed on any part of the body.

The modern, attractively designed cabinet is of all steel construction, finished in baked-on enamel. It is mounted on heavy duty, rubber tired swivel casters for easy mobility. The unit has two tubes and controls which ensure accurate regulation of frequency and uninterrupted treatment of the patient. It will deliver ample power for all diathermy purposes. **American Cystoscope Makers, Inc., Dept. MH, 1241 Lafayette Ave., New York 59. (Key No. 184)**

Bronchoscopic Table



The S-1515 Hudson Bronchoscopic Operating Table has been added to the line of major operating tables made by Shampaine. Especially designed for bronchoscopic surgery, the new table is arranged to obtain the necessary positions with simple and quick adjustments. Heavy-gauge polished stainless steel, heavily reenforced, covers the fulcrum-mounted table top which has body and head rest sections with adjustable foot rest and shoulder supports. **Shampaine Co., Dept. MH, 1920 S. Jefferson Ave., St. Louis 4, Mo. (Key No. 185)**

Seco-Superex Fountain Line

Seco-Superex soda fountain units and related equipment and accessories are now available to institutions throughout the country. The new line offers advanced mechanical and functional design which has been field tested for a period of 2½ years. Outstanding features of the line include all refrigeration compressors self-contained in each unit; dispensing equipment with self-contained cooler carbonator with large capacity; interchangeable units for planning any layout with or without food; custom-built, heavy duty construction with one-piece seamless stainless steel tops; dry refrigerator system and narrower fountain to reduce reach and fatigue. **Seco Company, Inc., Dept. MH, 5206 S. 38th St., St. Louis 16, Mo. (Key No. 186)**

Permapad

A bed pad and mattress protector which is made of various forms of specially treated glass, Permapad is easily washed or laundered, can be sterilized by dry heat or steam without affecting the fabric, is water-repellent, fireproof and sanitary. Permapad does not shrink, does not absorb odors, cannot sustain insects or bacteria, is mildewproof, rotproof and nonallergenic. It is available in single and double bed sizes and can be manufactured to any special sizes required. **The Stanley Mfg. Co., Dept. MH, 747 Santa Fe Drive, Denver 4, Colo. (Key No. 187)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 280

Oxygen Tent Humidifier

The new Walton oxygen tent humidifier uses the same procedure as the Walton Humidifier in producing a cold water vapor by mechanical means. By directing this vapor through a rubber hose, the unit maintains humidity in an oxygen tent while oxygen is being administered. The unit is capable of maintaining any desired humidity up to 95 per cent in the oxygen tent and will run between 8 and 10 hours without refilling. It uses a minimum of electrical current and evaporates a pint and a half of water per hour. The unit can be used as a room humidifier by removing the rubber hose. **The Walton Laboratories, Inc., Dept. MH, 1186 Grove St., Irvington 11, N.J. (Key No. 188)**

Feather Renovating Machine

The new Huebsch Feather Renovating Machine is designed to sanitize, restore and revitalize pillows that are flat and lumpy. Feathers are emptied into the hopper of the machine where fan suction automatically draws them into a processing bag. They are then treated with live steam and high temperature air which makes them soft and fluffy. Ticks are washed and ironed separately and the feathers replaced in the same manner in which they were originally removed from the tick.

The machine can be easily converted, by lifting out the removable hinge pin and removing the left hand door, to a regular four coil laundry tumbler when not needed for feather renovating. **Huebsch Mfg. Co., Dept. MH, 3744 N. Booth, Milwaukee 12, Wis. (Key No. 189)**

The "Silent Nurse"

A device to permit the patient to raise and lower the head or foot of his bed, known as the "Silent Nurse," has been introduced. When the patient is permitted to have his head elevated, the small aluminum control unit of the "Silent Nurse" is placed on the bed within easy reach of his hand. Two buttons, operated by simple pressure, control the operation of the bed.

Two silent motors beneath the bed operate the raising and lowering mechanism smoothly and slowly when the patient presses the buttons. The mechanism continues to move the head or foot of the bed so long as the button is pressed but movement stops immediately when the finger is removed. The device is designed to give the patient greater comfort and to save valuable nursing time and effort. The "Silent Nurse" is distributed by The Hill-Rom Company and manufactured by **Macston Corp., Dept. MH, San Diego, Calif. (Key No. 190)**

Kent Floor Conditioner

The new Kent Floor Conditioner offers a complete floor conditioning appliance in one unit. It wet scrubs, waxes, polishes, buffs, sands and steel wools.

The streamlined balanced design and two concentric brushes operating in opposite directions provide easily balanced operation. The automatic switch turns the conditioner on when the handle is in the operating position and off when the handle is in vertical position. The motor is built for long service and is permanently lubricated for the life of the machine.

One set of polishing brushes is standard equipment with the new machine. One scrubbing brush, 1 lamb's wool buffer, large polishing brush 9½ inches in diameter and small 5 inch polishing brush are available as de luxe equipment. The conditioner is finished in brown baked enamel. **Kent Electric Corp., Dept., MH, Rome, N.Y. (Key No. 191)**

X-Ray Film Hanger

A new clipless x-ray film hanger has been developed for use where many small films must be processed. It holds 14 films and is designed for instant loading and unloading, permitting rapid and clean processing of films with a minimum of effort. With the new hanger films will not stick together, do not shake loose from the hanger and have no clip holes. The hanger itself is made of stainless rustless alloy, is simple in construction and low in cost. **Bar-Ray Products, Inc., Dept. MH, 209 25th St., Brooklyn 32, N. Y. (Key No. 192)**

Kodak Utility Footswitch

The new Kodak Utility Footswitch has been designed for use with medical and dental x-ray processing white light illuminators, intermittently operated safelights and other operations. It is so designed that it can be operated equally well by the foot or, when attached to a table leg, by the operator's knee. It is equipped with a microswitch, a 6 foot cord and a plug and is designed for use with alternating current of not more than 125 volts. It has a built-in neon lamp emitting a dull orange glow for quickly locating the footswitch and has four rubber feet to prevent slipping on the floor. **Eastman Kodak Co., Dept. MH, Rochester 4, N.Y. (Key No. 193)**

Laboratory Demineralizer

The new Permutit Laboratory Demineralizer is designed to provide mineral-free, chemically pure water at low cost for laboratory use. The unit offers easy, accessible delivery of water from the service gooseneck or from an additional outlet at the rear where it can be piped to a storage tank overhead for distribution to any point in the laboratory. The two step demineralizing process operates simply and permits considerable savings in time and money over the use of bottled distilled water. **The Permutit Co., Dept. MH, 330 W. 42nd St., New York 19. (Key No. 194)**

Barwa Lounge

A new lounge chair, known as the Barwa, has been designed to give perfect relaxation and comfort through following the natural curves of the skeletal frame. It can be used in a semi-upright position or in a reclining position in which case the feet are approximately as high as the head. The design permits complete relaxation and rest and in the reclining position, circulation should be stimulated. The Barwa should be useful in patients' rooms, solariums, nurses' homes, employes' rest rooms and in many other areas in the hospital and sanatorium. **Barwa Associates, 177a N. Michigan Ave., Chicago 1. (Key No. 195)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 280

Amp-O-Vac

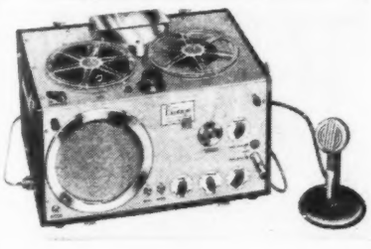
The Amp-O-Vac is a reusable ampule designed for use in the production and storage of procaine solutions, morphine sulfate, 50 per cent dextrose, small amounts of normal saline and other fluids dispensed by syringe and needle technic. The Amp-O-Vac is hermetically sealed after sterilization and an audible water hammer click denotes the presence of a vacuum.

All parts of the Amp-O-Vac are reusable with the exception of the rubber diaphragm which can be punctured as much as 20 times but should be replaced when the ampule is refilled. In use, all parts of the Amp-O-Vac are washed, rinsed well with distilled water and filled with the desired solution. The rubber bushing, cap, diaphragm and protective outer cap are assembled and the unit is autoclaved for 30 minutes at 250 degrees F. On removal the cap is pushed down and as the solution cools it vacuum packs, thus contents remain sterile indefinitely. The solution is withdrawn from the flask by removing the outer cap and inserting a needle through the rubber diaphragm. **Macalaster Bicknell Co., Dept. MH, 243 Broadway, Cambridge 39, Mass. (Key No. 196)**

"Ekotape" Portable Recorder

High power output, fine tone quality, simplified operation and versatility are features of the new "Ekotape" portable tape recorder. The unit is designed to overcome recording noises and tone-flutter. A large, powerful amplifier with separate channels for recording and listening, an 8 inch speaker and an oversize motor control tone quality and volume. Other features include: recording volume indicator eye; fast rewind and fast forward speeds without rethreading the tape; continuously operating motor drive and capstan permitting instantaneous tape start and stop; simplified mechanism to permit reaching any section of a recording quickly, and facilities for making recordings from a microphone, a radio tuner or a phonograph transducer.

Tape may be spliced and edited and



erased for repeated use. The unit may be used as a recorder, a player or as a public address system with its own or separate speakers or coupled to a larger sound system. It is housed in a carrying case with microphone, tape, cords and plugs. **Webster Electric Co., Dept. MH, Racine, Wis. (Key No. 197)**

Ceiling Suspension Germicidal Unit

Hanovia has developed a new ceiling suspension germicidal unit as an addition to the line of Safe-T-Aire fixtures. This model ST2832 provides indirect irradiation to the upper air and may be equipped with various types of Hanovia burners, depending upon the requirements of the room. The new unit is streamlined in design and finished in ivory Vitrolyn enamel. Two windows in the bottom of the fixture reflect the ultraviolet light and indicate when the lamp is operating. **Hanovia Chemical & Mfg. Co., Dept. MH, Newark 5, N.J. (Key No. 198)**

Wartenberg's Pinwheel

A new instrument for neurological examination has been developed by Sklar. Designed by Dr. Robert Wartenberg of the Medical School of the University of California, Wartenberg's Pinwheel is used to elicit various reflexes. It is made of chrome and the points of the revolving wheel are extremely sharp to produce the necessary stimuli. The instrument is sold in a felt lined, leatherette case to protect the pinwheel when not in use. **J. Sklar Mfg. Co., Dept. MH, 38-04 Woodside Ave., Long Island City 4, N. Y. (Key No. 199)**

Hilite Hospital Sheeting

Hilite is a new chemically produced material requiring no cotton base and containing no rubber, developed as a hospital sheeting. The material has a high tensile strength and a tearing strength of 325 pounds. It can be sterilized in the usual way, provides full protection on the hospital bed and is resistant to oils, acids, urine and other hospital liquids.

Hilite does not change under heat or cold and can be machine sewed to muslin or other material or to itself and can be electronically sealed to itself. It is available in 36, 45 and 54 inch widths, in standard 25 yard rolls, in maroon color. **The Bittner Corp., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 200)**

Corbin Electric Floor Machine

A low center of gravity and special reversing switch designed to prolong brush life are features of the new Corbin Floor Cleaning Machines recently announced. They are available in single or twin brush models, revolving brush type, and are designed for wet and dry scrubbing, waxing, shampooing, polishing, grinding, sanding and troweling.

A specially applied heavy duty ball-bearing capacitor start motor develops full power within the extremely low clearance. The low center of gravity provides easier control, balanced drive, extended brush life and reduced wear on machine parts. The motor is built into a one piece base of strong cast aluminum alloy. Other features of the new machines include adjustable handle which can be secured at any angle; electric safety switch with dual control levers extending under each insulated handle grip; double rubber bumpers around the base of the machine; baked-on enamel finish, and conventional wood-backed brushes and other accessories which are easily snapped into position and removed without tools. The new machines will be distributed by West Disinfecting Company, Long Island City, N.Y. **Corbin Screw Div., American Hardware Corp., Dept. MH, New Britain, Conn. (Key No. 201)**

Oxygen Analyzer

The new O.E.M. Simplified Oxygen Analyzer is completely enclosed in transparent plastic to prevent breakage. It is designed to permit an accurate analysis of oxygen content to be made within the oxygen tent canopy in less than a minute.

The unit is adaptable for instant use with every type of oxygen tent and is designed for simple operation, demanding no technical skill or detailed work on the part of personnel. Simple directions are indelibly printed on the analyzer. It is easy to clean and keep sanitary, easily portable and weighs only 2 pounds, 2 ounces. **Oxygen Equipment Mfg. Corp., Dept. MH, 405 E. 62nd St., New York 21. (Key No. 202)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 280

Improved "Fairprene" Sheeting

A new mattress cover and hospital sheeting of unusual strength has recently been announced by Du Pont. Sold under the "Fairprene" trade mark, the new product has a nylon base which is coated on both sides with neoprene synthetic rubber. This extra strong product was developed especially for use in mental institutions because of its high tensile strength and the fact that it is almost impossible to tear it.

The sheeting is resistant to oil, boiling water, steam and chemical sterilization. It resists cracking, peeling and sticking and has good abrasion resistance. It is available in standard size rolls of 50 yards or half rolls of 25 yards, 36 inches wide, and is known as "Fairprene" No. 9435-N. **E. I. du Pont de Nemours & Co., Inc., Dept. MH, Fairfield, Conn. (Key No. 203)**

Boonton Tableware

Boonton Tableware is a new line of dishware made of "Melmac," a synthetic which looks and feels like china but has exceptionally high resistance to chipping and cracking. The Boonton Tableware is light in weight, is easily cleaned and stacked, has low heat transmission which keeps food warm without the need of preheating the dishes, can be washed with standard dishwashing methods, is odorless, tasteless and non-toxic and is economical. Noise in handling is at a minimum.

The new ware is available in pastel blue, yellow and buff and the line includes compartment plate, dinner plate, dessert plate, lunch plate, bread and butter plate, cup, saucer, vegetable dish, soup dish, soup bowl and platter. **Boonton Molding Co., Dept. MH, Boonton, N.J. (Key No. 204)**

Portable Audiometer

The new ADC Model 53 portable audiometer is designed to provide superior hearing test equipment to hospitals, otologists and public health authorities at low cost. The double headset permits instant switching of the test tone from ear to ear. It avoids resetting controls when running routine tests and speeds testing of large groups. The dual receivers on the headband provide the advantage of constant pressure and proper alignment to the ear.

The built-in microphone speech circuit permits conversation with the severely deafened, testing for perception of speech sounds and other advantages. A special feature on Model 53-C is a masking device making it possible to isolate one ear while making bone conduction tests of the other. The unit is attractively cased in a natural oak cabinet and has an automatic voltage regulator which compensates for line voltage variations. **Audio Development Co., Dept. MH, 2833 - 13th Ave. S., Minneapolis 7, Minn. (Key No. 205)**

Light for Rh Factor Testing

The new Stocker & Yale Clinical Lamp provides facility for the rapid and accurate perception of agglutination by either slide or tube method in the Rh factor test. An even illumination intensity of 450 foot-candles coupled with the 2-power viewing lens resolves the fine details far more rapidly and accurately than by the naked eye and more simply than by microscope.

The lamp also provides utility for the study of Petri dish cultures of bacteria, either streaked or poured. The twin 4 watt fluorescent bulbs provide abundance of illumination and the magnifying lens enlarges the subject. The size, weight and portability of the Clinical Lamp permit its use for many other operations. It operates on 115 volts 60 cycle AC and may be used on DC by use of an adapter. **Stocker & Yale, Dept. MH, Marblehead, Mass. (Key No. 206)**

Grease Interceptor Control

Discharge from one or more fixtures through a grease interceptor can now be properly distributed through use of the Flow Control Tee recently perfected. The control guards against overloading due to sudden surges from sinks or other fixtures and maintains the flow so that the interceptor can operate at high efficiency.

The new Flow Control Tee is furnished with all Zurn Greaseptors and is available separately for use with present grease interceptor installations of any manufacture. The new Tee also provides proper venting and is equipped with a cleaning handle or plunger to remove solid material which may become wedged in the orifice. **J. A. Zurn Mfg. Co., Dept. MH, Erie, Pa. (Key No. 207)**

Steel-Wood Shelving

A new line of steel-wood shelving has been announced which is easy to set up, dismantle or rearrange because there are few parts to handle. All upright members are steel and the hardwood shelves are steel reenforced. A clip and stud system permits quick and easy shelf adjustment and vise-tight assembly of shelf to upright. The shelving is strong and safe, rigid and free standing and requires no bracing to wall or ceiling. **Lyon Metal Products, Inc., Dept. MH, Aurora, Ill. (Key No. 208)**

Pharmaceuticals

Duracillin, in Oil

Duracillin, in Oil, is a procaine penicillin G in oil which is absorbed slowly from body tissues and which is relatively painless on injection. Blood concentrations from a single 300,000 unit injection are said to remain at optimum levels for more than 24 hours. The physical form of the product permits convenient administration and it is supplied in 10 cc. rubber-stoppered multiple-dose ampules. **Eli Lilly and Company, Dept. MH, Indianapolis 6, Ind. (Key No. 209)**

Name Changes

The combined vaccine for simultaneous immunization against diphtheria, pertussis and tetanus is now being marketed by Cutter under the new trade name, Dip-Pert-Tet.

A new name, B.I.P., has also been announced by this company for their arthritis vaccine. Formerly called Sherwood Formula, B.I.P. (an abbreviation for Bacterial Intravenous Protein) is designed for intravenous therapy based on desensitization against offending bacterial proteins. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 210)**

Methadon Hydrochloride

Methadon Hydrochloride is a synthetic, morphine-like drug which is soluble in water or alcohol. This analgesic has less of the undesirable side effects of morphine but is not effective in relieving labor pains and not recommended for preoperative use. It is supplied in hypodermic and compressed tablets and in sterile solution for oral or subcutaneous administration. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 211)**

Sulfa Products

Two new sulfa products have been announced by Abbott. Trazoline is Abbott's compound of sulfadiazine, sulfamerazine and sulfathiazole in tablet form, grooved. They are designed for oral administration in the treatment of any acute bacterial infection in which the component drugs are indicated and are supplied in bottles of 100 and 1000 tablets.

Sulfedexan is a stabilized solution of sodium sulfacetimide and d-desoxyephedrine hydrochloride for local application to the nose and throat when antibacterial and vasoconstrictor effects are desired. It is supplied in 1 fluid ounce and in 1 pint bottles. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 212)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 280

Neo-Antergan

Neo-Antergan is described as a new antihistaminic of low toxicity which has proved effective in preventing or relieving symptoms in a high percentage of patients with certain allergic manifestations, including allergic drug reactions due to penicillin and streptomycin. The product is supplied in coated tablets of 25 and 50 mg., in boxes of 100 tablets. **Merck & Co., Inc., Dept. MH, Rahway, N.J. (Key No. 213)**

ACR-Allantomide Ointment

ACR-Allantomide Ointment is a combination of 9-amino-acridine hydrochloride 1:500, sulfanilamide 10 per cent and allantoin 2 per cent, in an aromatized water miscible base. The new antiseptic ointment possesses a wide bacterial spectrum against certain anaerobes, gram-positive cocci and bacilli and gram-negative bacilli, including Proteus. It is available in 1 ounce tubes and 1 pound jars. **The National Drug Co., Dept. MH, 4663 Stenton Ave., Philadelphia 44, Pa. (Key No. 214)**

Vi-Syneral Injectable

Vi-Syneral Injectable combines 8 vitamins in one stable, clear solution, solubilized in an aqueous base for parenteral use to replenish vitamin-deficient tissues. It is ready for immediate use for intramuscular injection without mixing, diluting or heating. This new product, oil-soluble and water-soluble vitamins in aqueous solution, is supplied in 2 cc. ampules, in boxes of 6, 25, 100 and 500. **U. S. Vitamin Corp., Dept. MH, 250 E. 43rd St., New York 17. (Key No. 215)**

Anatex "Rorer"

Anatex "Rorer" is a new laxative employing methylcellulose in palatable granular form. It is described as acting by water-absorption, producing a viscous colloidal solution. It is unabsorbed by the body and lubricates and protects the mucosal lining of the intestines. It is supplied in 100 Gm. bottles. **Wm. H. Rorer, Inc., Dept. MH, 901 Drexel Bldg., Philadelphia 6, Pa. (Key No. 216)**

Sodium Sulfacetimide Nasal Solution

Sodium Sulfacetimide Nasal Solution 10% is an aqueous solution designed to prevent colds if treatment is instituted promptly. It is a non-irritating solution with excellent penetrating powers which affects the nasal musoca beneficially. **Schering Corp., Dept. MH, Bloomfield, N.J. (Key No. 217)**

Product Literature

• Complete descriptive information on the line of **"Seamless Hospital Standard Urinals"** is given in a booklet released by The Seamless Rubber Co., New Haven 3, Conn. The line has been completely redesigned after consultation with GU specialists and representatives of the U. S. Veterans Administration and the booklet covers all details on the product and the interchangeable parts available. **(Key No. 218)**

• The new **catalog** issued by Everest and Jennings, 7748 Santa Monica Blvd., Los Angeles 46, Calif., is a comprehensive booklet giving detailed information on the full line of wheel chairs and accessories manufactured by this company. The 34 page book lists over 25 separate wheel chair models, all the folding type, many wheel chair accessories and replacement parts with full price and shipping weight information. **(Key No. 219)**

• A file folder size chart entitled **"Ready Reference of Employees' Uniform Sizes"** has been developed by Angelica Jacket Co., 1419 Olive St., St. Louis 3, Mo., as a convenience in keeping a permanent record of employees' uniform sizes. Space for keeping the record is given on the face of the chart while a uniform measuring chart and instructions for ordering are on the reverse side. **(Key No. 220)**

• A complete new catalog, printed in color, has been issued by The Silex Company, Hartford 2, Conn. Known as **Form REC-148,** the new catalog illustrates and describes each model of the Silex gas and electric coffee making units, replacement parts and accessories and has a section devoted to the several new items in the Silex line. **(Key No. 221)**

• An outline of recommendations for retention of records is presented in the booklet, **"Business Records Classification and Retention Recommendations,"** issued by Diebold, Inc., Canton 2, Ohio. The booklet is designed to assist in making a record retention schedule from which a program of retention and storage, to save time and space, can be planned. **(Key No. 222)**

• Information on **"Flexicore Floor and Roof Slab"** is given in detail in a booklet recently issued by The Flexicore Co., Inc., Dayton 1, Ohio, and distributed by Price Brothers Co., 1932 E. Monument Ave., Dayton 1, Ohio. This precast, precured, hollow-cast concrete slab with prestressed-steel reenforcement for all types of building construction is fully described with blueprint type drawings to illustrate its uses for wall, roof, floor, plumbing and wiring installations. **(Key No. 223)**

• The new **Ethicon Needle Suture Catalog N-108,** issued by Ethicon Suture Laboratories, New Brunswick, N. J., gives all necessary information for ordering sutures with swaged Atraloc needles. Taper point needles are listed in the first group, followed by the cutting point needles on pages 3 and 4. The new Atraloc eyeless needle is illustrated with details of its strength and ease of use offered on the first page. Each needle cataloged is illustrated and details are given on material, length and boilable and non-boilable types. **(Key No. 224)**

• A detailed account of how a group of cultural, educational and medical institutions cooperated most effectively to achieve a practical central heating system covering an extensive area is given in a brochure, **"Pittsburgh's Great Institutions Join Forces for Central Heating,"** Form No. 4713, issued by The RicwiL Company, Union Commerce Bldg., Cleveland 14, Ohio. **(Key No. 225)**

• A new booklet on **"Pyrex" Brand Fritted Glassware** has been issued by Corning Glass Works, Corning, N. Y., and presents some original experimental data on the flow of distilled water and air through fritted glass filter discs. The cleaning of fritted filters, pressure and thermal recommendations, and a comparative study on gas washing bottles using fritted filters and plain tubes are other subjects which should prove of interest and assistance to those responsible for laboratory procedures. **(Key No. 226)**

• A new roofing repair process system developed by United Laboratories, Inc., 16801 Euclid Ave., Cleveland 12, Ohio, is described in a brochure published by that company. Entitled **"Protect That Roof! . . . it's good insurance,"** the brochure gives complete details on why good roof protection is essential and on the specific process recommended for each type of roof. **(Key No. 227)**

• Two bulletins on the effectiveness of Chlordane, the all-purpose insecticide, in the control of roaches and ants have been issued by the Chemical Corporation of Colorado, Denver, Colo. Entitled **"Eradication of Roaches"** and **"Direct Control of Ants,"** the booklets give technical information on procedure, as well as data on the product. **(Key No. 228)**

• **"Marble Forecast 1948-1949"** is the title of a booklet which describes the varieties, colors and classifications of foreign and domestic marbles available for immediate installation in new construction projects and modernization programs. The booklet has been prepared by the Marble Institute of America, Inc., 108 Forster Ave., Mt. Vernon, N. Y. **(Key No. 229)**

• **"Midland Maintenance and Sanitation Products for Hospitals"** are described in a folder issued by Midland Laboratories, Dubuque, Iowa. Specialized hospital products are listed with information on qualities and uses. **(Key No. 230)**

• The tenth booklet of a **series of charted guides** to answer painting questions has been issued by American-Marietta Co., 43 E. Ohio St., Chicago 11. The institutions folder has a chart arrangement giving correct primers and finish coats for every institutional use including a no-odor paint which should be of particular interest to hospital administrators and maintenance departments. **(Key No. 231)**

• The use of glass block in public buildings is illustrated in a 12 page booklet, **"Daylight in Public Buildings,"** available from American Structural Products Co., Toledo 1, Ohio, a subsidiary of Owens-Illinois Glass Co. A section devoted to the use of glass block in hospitals shows operating rooms and clinics, kitchens and laundries and a nursery with Insulux glass block as fenestration material. **(Key No. 232)**

• A new leaflet has been prepared by Marsh Wall Products, Inc., Dover, Ohio, on the use of Marlite in hospitals. Entitled **"Marlite Plastic-Finished Wall Paneling for Walls and Ceilings Which Beautifully Reflect Modern Hospital Efficiency,"** the leaflet describes the advantages of this paneling which is sealed against penetration by moisture, dirt, greases, alkalis, most acids and chemical fumes, and describes the attractive colors and patterns available. **(Key No. 233)**

• The Commodity Standards Division of the National Bureau of Standards, U.S. Department of Commerce, Washington 25, D.C., announces the availability of printed copies of **Commercial Standard CS145-47, Testing and Rating Hand-Fired Hot-Water-Supply Boilers.** Copies may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 10 cents each. **(Key No. 234)**

• How electricity is made available anywhere with **portable electric generating plants** that can be carried, wheeled or trucked to the job is shown in a new folder recently released by D. W. Onan and Sons Inc., Minneapolis 5, Minn. Onan electric plants, ranging from 350 watts to 3000 watts alternating current, are pictured and described as well as direct current models and water-cooled, large capacity electric plants. **(Key No. 235)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 168 Film Reader-Desk
- ☐ 169 Visiband Dressing
- ☐ 170 Bobtail Fountain
- ☐ 171 Stainless Steel Tea Set
- ☐ 172 Centralinear Vertical Control
- ☐ 173 Nylon Hand Brush
- ☐ 174 Sempra Syringe
- ☐ 175 Dishwashing Machines
- ☐ 176 Oxygen Administering Apparatus
- ☐ 177 Tool Kit
- ☐ 178 Automatic Ice Cube Maker
- ☐ 179 Advanced Design Metal Desks
- ☐ 180 Underwood Duplex Machine
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- ☐ 200 Hilite Hospital Sheeting
- ☐ 201 Electric Floor Machine
- ☐ 202 Oxygen Analyzer
- ☐ 203 Improved "Fairprene" Sheeting
- ☐ 204 Boonton Tableware
- ☐ 205 Portable Audiometer
- ☐ 206 Light for RH Factor Testing
- ☐ 207 Grease Interceptor Control
- ☐ 208 Steel-Wood Shelving
- ☐ 209 Duracillin, in Oil
- ☐ 210 Name Changes
- ☐ 211 Methadon Hydrochloride
- ☐ 212 Sulfa Products
- ☐ 213 Neo-Antergan
- ☐ 214 ACR-Allantomide Ointment
- ☐ 215 Vi-Syneral Injectable
- ☐ 216 Anatex "Rorer"
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Book Announcements

Observer Printing House, Inc., Charlotte, N. C. "The Small General Hospital, Procedures in Record Keeping," Bulletin No. 1, with Sample Forms, revised April 1948. **(Key No. 236)**

Physicians' Record Co., 161 W. Harrison St., Chicago 5. Huffman, "Manual for Medical Records Librarians," 2nd ed., revised and enlarged, 400 pp., $4.50. **(Key No. 237)**

W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. Long, "A-B-C's of Sulfonamide and Antibiotic Therapy," 231 pp., $3.50. Maximow, "A Textbook of Histology," 5th ed., 700 pp., $8.50. Montag and Filson, "Nursing Arts," 603 pp., $3.50. DeRobertis, Nowinski and Saez, "General Cystology," 345 pp., $5.50. **(Key No. 238)**

Suppliers' Plant News

Bauer & Black, 2500 S. Dearborn St., Chicago 16, manufacturer of hospital and surgical supplies, announces the purchase of the Burson Knitting Co., Rockford, Ill., manufacturer of elastic stockings and knitted hosiery specialties. **(Key No. 239)**

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